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VOL. 8

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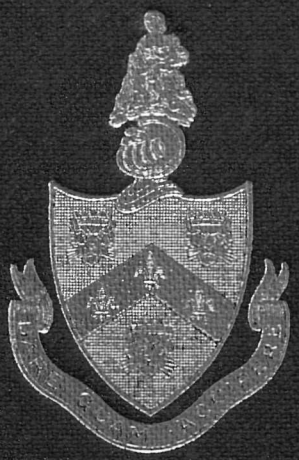

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Notice.

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The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

JANUARY 13, 1894.

A Retrospect.

SEVEN long years are now enrolled in the annals of the past since the day on which the first Number of the new series of the GUY'S HOSPITAL GAZETTE started on its first voyage, with Leonard Braddon at the helm of office, with Drs. E. H. Starling and R. M. H. Randell as his mates, and with many others giving willing and excellent labour for the Guyites of then and now.

The previous effort had died—hardly, perhaps, a natural death—in 1879, but in 1887 the GAZETTE was re-established owing to a proposition laid before the opening meeting of the Physical Society, which was the "outcome of a yearning felt in literary circles—after the defunction of our lamented ancestor—growing slowly to an intense desire."

How vast the changes are which have occurred since the sickle was again put in the harvest of Guyites' literary crop, must be apparent to everyone—changes in the Hospital, alteration of appointments, while death has everywhere been busy around us; such things need no demonstration from our pen. Then again, the mighty Journal itself has changed—as we never cease to proclaim—from twelve pages we have risen to twenty, simply crammed to contain *part* of the doings of Guy's men in the field and wards, and of the sayings of all our noted Teachers. Yes. We think we may say that the child now growing up has, with tender care, improved, and shows the good effects of its tuition; but still in such a case as this there should be no such thing as content—we have always thought this the meanest of all good qualities.

We should like to see the writings of a greater variety of men adorning our pages, and to be the more frequent means of putting before the world of Guy's the living inspirations of future ornaments to *the* profession.

And, while our thoughts take this turn, they suddenly flash back to the memory of one of the greatest and most brilliant literary geniuses Guy's has ever held, Dr. Moxon—we of the present generation never knew him, such is our frequent lament. Of his extraordinary and far-stretching knowledge we need not speak; but we must note just one point in his life—of the "deceased ancestor" just spoken of—he was a staunch supporter and an eloquent contributor, when his bright and fanciful imagination, subtle genius and queer premises, passed like a golden thread amongst the baser material bearing other signatures. Such comparison need never be odious.

Moreover, we are again reminded of him in that the infant of January, 1887, specially mourns the death of Pilocereus, "whose friendship was as priceless as a substitute for it was .mpossible." Such was the man who proposed for himself the epitaph, "He understood Nothing," while among many epigrams, sparkling with wit, he opined that theorists are people who "look soberly only on conclusions, and—if I may so speak—are drunk on the premises." One stanza we cull from the poem "In Memory of Walter Moxon":—

> "The warmest heart that ever beat,
> The firmest friend who ever stood;
> His presence seemed as one should meet
> A god—among the multitude."

By the kindness of Mrs. Moxon—who published, in 1887, "Pilocereus Senilis," in the hope that it might interest the past and present students, and dedicated the volume to them—we are enabled to commence in this and continue in our following issues, a lecture by the late Dr. Moxon, for the benefit chiefly of present and future Guy's men. It appeared in the above-mentioned collection of his works.

We take this opportunity, in the name of the students of the present and future, of thanking Mrs. Moxon for the additional proof of her love for her home of old, and its inhabitants.

How should we study Medicine?

THE LECTURE INTRODUCTORY TO SESSION 1868-9, AT GUY'S HOSPITAL.

BY WALTER MOXON, M.D.,

FELLOW OF THE ROYAL COLLEGE OF PHYSICIANS.

Ἐὰν τὸ παρὸν ἐνεργῇς, ἑπόμενος τῷ ὀρθῷ λόγῳ ἐσπουδασμένως, ἐῤῥωμένως, εὐμενῶς, καὶ μηδὲν παρεμπόρευμα ἀλλὰ τὸν ἑαυτοῦ δαίμονα καθαρὸν ἑστῶτα τηρῇς, ὡς εἰ καὶ ἤδη ἀποδοῦναι δέοι. ἐὰν τοῦτο συνάπτῃς, μηδὲν περιμένων, μηδὲ φεύγων, ἀλλὰ τῇ παρούσῃ κατὰ φύσιν ἐνεργείᾳ, καὶ τῇ, ὦν λέγεις καὶ φθέγγῃ, ἡρωϊκῇ ἀληθείᾳ ἀρκούμενος, εὐζωήσεις. Ἔστι δὲ οὐδεὶς ὁ τοῦτο κωλῦσαι δυνάμενος.

IMP. M. ANTONINI, III. 12.

GENTLEMEN,—When we begin anything, whether it is a course of study, or a lecture introductory to one, the first thing we have to do, is to take a clear and comprehensive view of what we intend to achieve. We are beginning together. When I have ended my little task, I shall only have made clear to you what a great task you will have but just begun. I have settled what I mean to do, and it is this:—To give you the same help in your first duty of preliminary survey as these my colleagues will give you in all the steps of your further progress. And I will commence by offering you advice which I know each of them will repeat in his turn:—Don't let what you hear from me stand to you in the place of your own thoughtful observation and inquiry. Think out your own view of the profession honestly, liberally, and truthfully.

There is this difference between starting life as children, and starting life as men:—that as children we find ourselves in responsibilities that we did not undertake—we are placed in our respective cradles without the slightest consultation of our feelings or preferences; but as young men we choose deliberately what kind of citizens we prefer to become.

Perhaps we have all of us sometimes thought it rather hard upon us that we should be launched, whether we like it or no, and made into little boys without having a chance of first of all taking a good look at the sort of life we are to lead; and we flatter ourselves that if we could have had a notion of what was coming, we should have been better boys, and left undone many naughty things that we ought not to have done, but did do, and done many things that we ought to have done, but didn't do; and so we make a very reasonable excuse for ourselves. But now you are making a greater start in life than when you were first cradled, and you have the privilege, and you must use it too, of looking well before you, and seeing what you have to do, and preparing to do it well as you can.

Before we commence some trade or profession, we are like social fœtuses. The progress of social development is also from the general to the special. There is an absence of what is called differentiation in boys, corresponding exactly to what physiologists tell us of in the early development of mammals. They tell us that a rather clever man cannot at first say whether the little creature is going to be a cat or a monkey, and this doubtful state hangs about it until it gets its teeth and nails, and the rest of its means of working for its living, and then any one can see what it is. You see, the characteristic qualities come when a thing has to do its real work in the world; and when these come out, the more general (and hence useless) qualities, which had been upon the surface hitherto, go out of sight, to be hunted after by comparative anatomists. Now, in just the same way are we, as boys, all one with the rest of boys, and show the same general but useless characters which we share with young clergymen, and lawyers, and merchants; but now that we are to differentiate into doctors, those boyish appearances and manners must recede into the depths of our nature, and we must develope the qualities of physicians and surgeons.

It is plain enough, that the calling which a man is trained to, does require a growth of some of his faculties and tastes, and a suppression of others, until he becomes adapted in the kind of his intelligence and degree of his activity to the particular sort of duty he has to do. Every man's mind is like a little Darwinian world, in which different ideas struggle for existence, and those maintain their place in living thought which are best adapted to circumstances. Reason in your minds must take the place Man takes in Nature. It must aid in the struggle those ideas which are most profitable and suitable. Society makes room for the arts she requires, and she demands such people as can fit themselves to the spaces she allots. I don't know why else you should name them "callings." The very character of the person required is pre-arranged in the space left for him, and all the corners of that space he, or somebody more suitable, will fill. Some of the avocations in which men are forced to spend their lives offer little encouragement to the higher faculties of human nature. In every trade, and in many professions, a man, if he is to be human at all, must rise above his calling. But I can congratulate you on having chosen a vocation which must be always above you, demanding of you to the very close of your lives further advances, and at the end, leaving you far from being complete physicians. I would not disparage the men who follow other callings than our own. The business of a man's life is done between two powers: one is this power of society, whereby he is moulded to the place he takes; but there is another individual power, which always tries to be better than the world wants

him to be. Now, this last individual desire is equally strong in all sound men, and it has often raised, and will raise again, many a man far above the height of personal worth and grasp of knowledge that his mere avocation requires. But I may compliment you on this, that the social need you are going to serve will join with the best wishes in your nature to demand of you that you be good men.

We contrast trades and professions as if they were different, and yet I am not sure that the distinction between them is very well defined. I shall not attempt to give a definition of a profession, but content myself with pointing out this—that every calling which deserves the name of a profession has this character which distinguishes it from trades, that each member—for himself—directly uses general principles in the practice of such profession. He must be free to follow general principles on his own judgment and responsibility. If he follows stated rule, he is an artizan. If his course is dictated by the laws of commodity, he is a trader.

I want your special attention to this freedom of individual judgment which you have to fit yourself for. No man who is not worthy to be free has a right to enter our profession. This free, ready, original judgment you will have to use on all occasions by the bedside. It will be the very substance, and the test of your value in the world.

Now, I want to warn you of what may spoil you in the making, if you don't take care betimes. It is a very insidious danger, and it threatens all the more seriously, because it is brought upon you by very friendly and trustworthy, but far too numerous powers. I mean that crowd of Council, and Universities, and Colleges, and Faculties, and Halls, in irrelative repetition, who, to the disgrace of our country, will compete for you like so many mother birds struggling over a nest while the eggs cool. This is the danger:—You have to get, and store away in your memories, a vast quantity of knowledge. I tremble for you, when I think how much, because of the great danger that this bulk of knowledge may be too much for you, it may sink that individual judgment which you must above all things maintain. Knowledge is fuel, not fire. It is excellent fuel, but, by order of the colleges, it will have to be thrust into you in heaps, and, unless you take care, it will smother the spark of active intelligence which, if the fuel is added with proper care, will light it all ablaze, to glow upon and cheer your future patients. Mind the fuel does not come faster than you can master it, or you will be more like a coal scuttle than a fire. Knowledge is but a body, of which intelligence is the soul. I fear, lest you get more body than you have soul for. We want you always to be more than your knowledge, that you may be equal to the handling of it. Let us look together well at this danger, that we may see how it may be overcome, and even turned to excellent account.

First, see clearly your critical position. These very noble and esteemed good—but, as I said before, unmeaningly or extortionately numerous—masters, the Council, Universities, Colleges, etc., as before, are just now placing their hands to your shoulders, and they will bind your freedom, and do with you what they will, and make you, instead of the free-breathing creature you are now, into a machine, while you are as it were beside yourself in a sort of abeyance for four or five years; and then they will hand you over the machine to drive where you think you can make the most of it.

Now, before you plunge headlong into Anatomy, and Chemistry, and Zoology, and Physiology, and Comparative Anatomy, and Botany, and Materia Medica, and Pathology, and Hygiene, and Medical Jurisprudence, and Morbid Anatomy, and Midwifery, and Surgery, and Medicine, and all the rest, pray be quite sure you know what kind of a thing it is to learn. We human beings are a preposterous race; we do things hind-side before: why see—we first talk, and then learn the art of language. We first reason, and then we learn the art of logic. We first learn, and afterwards we study the art of learning. Now, for once, let us be beforehand, and ask, What is it to learn?

I will so far answer that question as to tell you a few things it is not, which it yet is apt to seem to be, because of the collateral meaning of the common words we use when we speak of learning.

Why the very words I began with are examples. I said you would have to *get* a *store* of knowledge. And again, for another instance out of many, we speak of a man's *capacity*.

These are bad words, gentlemen. We must learn not to look upon knowledge as stuff to store into capacities as if the relation of knowledge to the mind were the same as the relation of old curiosities to a lumber-room. No! It is not capacity and storage. The knowledge that enters does not find room, it makes room. It is poor, stunted stuff, if, when it gets in, it does not grow. It will make poor growth if it does not grow in harmony and adaptation to what is already there, and unite and develope with it. The educated mind is not a stuffed bag. It is true of the mind as it is true of the body. "It cometh forth like a flower," though it is never cut down. The mind is a growth.

Let me here warn you against a pestilent folly that some young men are liable to. You will meet foolish young men laying themselves out to get a reputation for a large unfilled capacity, or, as they like it said—"A very clever fellow, but he doesn't work." As though a general should glory in the little he does with such a great army. But it is all imaginary. Never believe him. It is an empty boast of a sham flatulency—a very vanity of vanity. The mind is never bigger than what it holds.

Sometimes we say we learn by getting the seeds of knowledge. No; that is not it; it is not even the seed that enters. The mind is not a mere soil for seeds to play pranks in. I will tell you what it is rather. The book or the teacher gives you vivifying elements which you have to receive with a responding activity. That is what I mean. Your function is receptive activity. You must take what you hear and read, not like a money-bag

gets a shilling, but as the germ receives the pollen, *with receptive activity*, and then in you will form a growing seed of knowledge with a whole active life before it. We shall impregnate your minds, and the knowledge begotten will take in you a new lease of life, and come out in forms like the father-thoughts that begot them, but we will hope a little better that the race of living knowledge may improve. And then yours shall breed a yet better knowledge in those in whom with equal love it propagates itself.

Such, gentlemen, is true learning, and I wish I could hope that all you acquire in this theatre will be thus a flourishing and harmonious growth. But I am afraid it will not. For whether they are misled by the bad words I have held up to you or not, most men seek knowledge as if it were to be taken, like nasty physic, in spoonfuls; and some teach it as if it were to be administered after the same fashion, They ignore this great truth, which please write down:—

Nothing is established in the mind, except as the answer to a question asked by the mind.

And so the student falls asleep over his book, because, forsooth, he has no interest in a fact that someone spent half a life in discovering. Why is that? The student is not asking that question which the discoverer asked. Pray see that each earlier step in knowledge demands the next, and prepares for it a definite question. If it is not so at any time, then know this, that you have not done well what you have done before. You have muddled the natural course of inquiry, and hence you ask no definite question. And how can you care for or keep an answer. You feel you seek in vain, for having you cannot hold.

So you complain, poor fellow, that the inquiry is difficult; which is absurd, for inquiry cannot be difficult, for inquiry is interesting. And *interest neutralizes difficulty as alkalies neutralize acids.*

The lecturer, or book too, on the other part, is apt to put what has to be taught, without regard to whether or no the student is ready to ask for the answer he is giving. It is so difficult for a teacher to remember how he got what he has got, and how long he was about it. Having slowly mastered his own ignorance, he forgets that he must with equal patience struggle with that of others. So he gives a lot of answers when the student has not framed the questions, which is as though he took cuttings from his best exotics, and stuck them in the poor student's cabbage garden, where the soil is not yet enriched with the mould of thirty years' learning.

Such, gentlemen, is learning in relation to the mind of the learner. But that is only one side of our question, "What is it to learn?" The other side of that question is, "What is learning in relation to the thing learnt?" or "How does the kind of science or knowledge we are studying affect our ways and means of learning?" This is the vital question of to-day, "In what way must we study medicine?"

(To be continued.)

Clinical Lecture on Pernicious Anæmia

BY DR. HALE WHITE.

GENTLEMEN,—We have recently had in the Hospital a man who has died from pernicious anæmia, and I am able to shew you his viscera, and also shall, in a few minutes, bring into the theatre a woman who is a well marked example of the disease, and you can see a man in Stephen who probably has it. We ought therefore this afternoon to be able to learn a good deal about this rare malady.

The clinical history of the fatal case is this.—On admission on March 8th, he was fifty-five years of age. He contracted gonorrhœa and syphilis when young, otherwise he had had no illnesses. He had not suffered from diarrhœa or sickness.

Present illness.—Eight weeks ago he began to feel weak and lose colour. Five weeks ago the dyspnœa and weakness became so marked that he had to take to his bed. At this time the ankles swelled. The pallor has increased, and the weakness is now so great that he cannot stand.

On admission.—The whole of the body is of a well marked lemon tint, but there is no jaundice. There is a flush over each malar bone. All the visible mucous membranes are very pale.

Circulatory system.—There is no evidence of cardiac dilatation. There is a loud blowing systolic murmur best heard at the apex and traceable from there in all directions. Pulse 80, regular, feeble, small compressible. Red corpuscles 24 per cent. Hæmoglobin 18 per cent. No leucocytosis.

Respiratory system.—This appears normal.

Alimentary system.—Tongue and mouth very pale, appetite bad, stomach a little distended, no vomiting, motions normal. The edge of the liver can be felt three quarters of an inch below the ribs. The spleen cannot be felt.

Nervous system.—Normal. He is sometimes giddy.

Eyes.—In both eyes there are several well marked hæmorrhages, which follow more or less the course of the vessels. The inner side of the right disc is a little blurred.

Urine.—Distinctly dark, no deposit. Sp. gr. 1012, free from blood, albumin, sugar, or bile.

He was treated with full diet and five minims of liquor arsenicalis daily.

May 27th.—Patient weaker and somewhat drowsy. He has been kept on arsenic except when the increase to seven minims seemed to cause diarrhœa. The liver is now three inches below the ribs.

June 15th.—The dyspnœa is very marked. There is Cheyne-Stokes' breathing. The liver is within an inch of the umbilicus. There is a pericardial rub.

17th.—He died comatose.

Autopsy—Heart.—Recent pericarditis. Well marked tabby striation.

Lungs.—Fifteen ounces of clear fluid in each chest. Lungs anæmic.

Spleen.—Soft, appeared normal.

Liver.—Sixty-six ounces. Appeared normal.

Kidneys.—Œdematous and tough. Bones normal. All the other parts of the body had nothing visibly amiss with them except anæmia.

The liver and kidneys, as you can see by the pieces of the organs I show you, stained blue with ferrocyanide of potassium and hydrochloric acid, and the liver gave a black colour with ammonium sulphide. The spleen also gave the blue reaction.

Subsequent analysis by Mr. F. G. Hopkins showed that the liver contained, when dried, freed from blood, and analysed with the greatest care, 1·038 per cent. of iron. (The normal percentage of iron in the liver is 0·083.)

The spleen, dried and freed from blood, contained 0·301 per cent. of iron. (The normal percentage of iron in the spleen is 0·171 per cent.)

State of the blood during the patient's stay in the Hospital.

Reaction.—The alkalinity of the blood was tested on March 14th with graduated litmus papers of different degrees of acidity. It could not be made out that the patient's blood differed from that of a healthy individual, but the test appeared far from delicate.

Specific gravity.—On June 10th, this was taken in a mixture of chloroform and xylol, and was found to be 1042.

The following chart shows the proportion of hæmoglobin and red blood corpuscles.

The urine.—This was carefully examined every day, and the following is a summary of the results:—

Quantity.—This varied, but not more than in health, and was usually about two pints.

Specific gravity.—This was nearly always between 1010 and 1012.

Albumin.—None, except a trace the day before death.

Indican.—This gradually appeared, as the urine got darker from April 14th, and increased, until at the end of the case, there was a considerable amount.

Colour.—The colour from admission up to April 1st was decidedly dark, and the urine was clear. From April 1st to April 14th colour normal; urine not clear. From April 14th it gradually passed through the stage of high colour to darkness, so that by April 25th it was moderately dark and clear. On May 1st it was dark and clear. On May 18th it was very dark and clear, and it remained in this condition till the death of the patient. The specimen before you shows very well the dark colour. Whenever the urine was dark, or very dark, the urobilin band was broad; in fact, the width of the band increased proportionally to the darkness. On no occasion, although repeated examinations were made, could any accessory spectral bands be detected, the only one visible being the broad urobilin band (which you can see in the present specimen). On several occasions the colour was observed in each specimen, passed at different times of the day, and it could not be made out that the time at which the urine was passed made any difference to the colour.

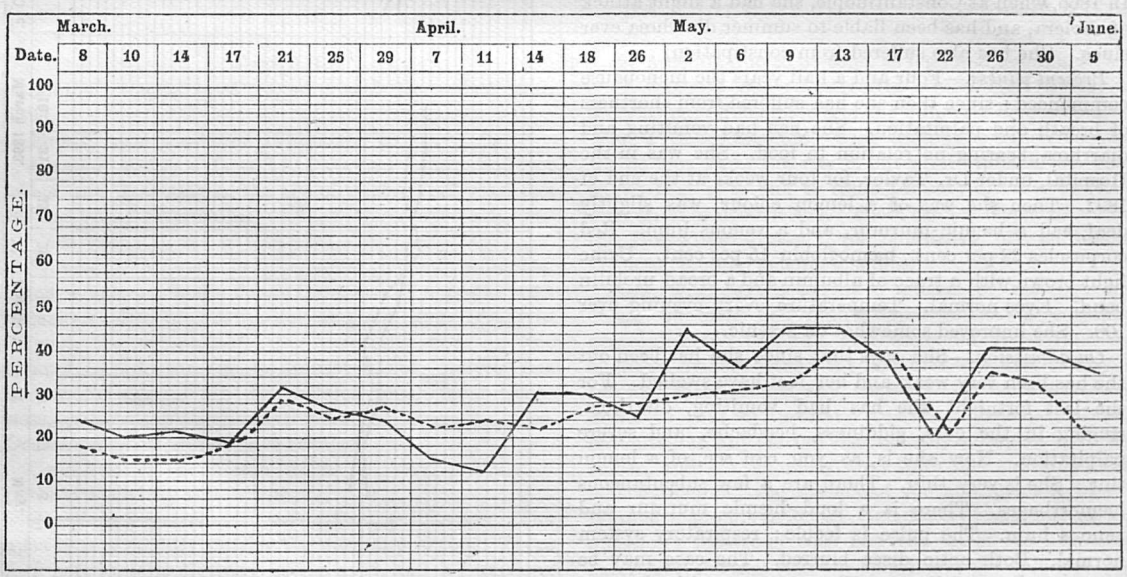
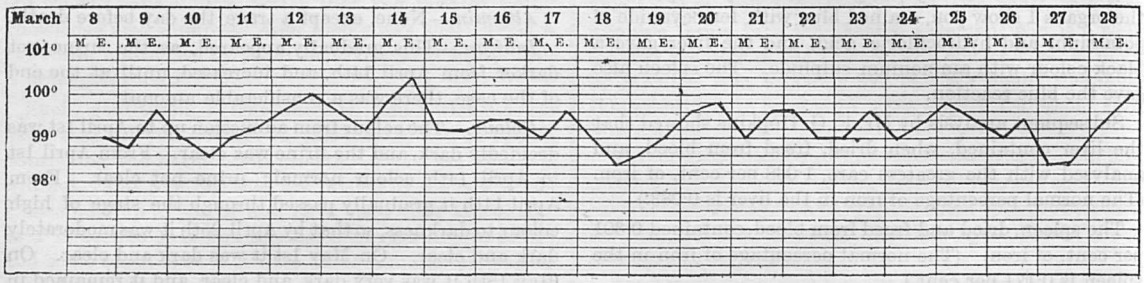


CHART OF THE BLOOD OF RICHARD FORGE.

Black line. ——— Percentage of red blood corpuscles. Dotted line. --------- Percentage of hæmoglobin

The temperature.—This was raised during the whole of the patient's stay in the Hospital. Usually it was a degree or so above normal, higher in the evening than in the morning. The following chart shows the temperature during the first three weeks :—



Microscopical examination of the viscera.—Pieces of the organs which had been stained with ferrocyanide of potassium and hydrochloric acid were cut in sections, and you can examine some kindly exhibited by Mr. Steward under the microscopes on the table. You will observe that in the liver the deposit of Prussian blue is in the outer two-thirds of the hepatic lobule, and is most abundant in the hepatic cells. In the kidney it is in the cells of the convoluted tubes, with a little lying free in the lumen of the tubes.

CASE II.

Annie G., æt. about 48, admitted March 18th, 1893. In 1866, when at Constantinople, she had a slight attack of cholera, and has been liable to summer diarrhœa ever since. She has also suffered from constipation.

Present illness.—Four and a half years the menopause commenced; since then she has suffered from shortness of breath and palpitation. She has had vomiting and diarrhœa, bearing no relation to food. She was in the Hospital, under Dr. Taylor, for four weeks at the end of 1892. Then she was of a lemon colour, was slightly deaf, had a hæmic murmur, and a venous hum. Red corpuscles 22 per cent., hæmoglobin 15 per cent. Urine light brown with a trace of albumin and a broad urobilin band. Eyes normal. Temperature every evening over 100. She improved somewhat on arsenic.

On admission.—She says that since she has been out she has been very weak and her feet have swelled. For the last fortnight she has had vomiting, diarrhœa, ringing in the ears, giddiness, headache, and severe palpitation. Now she is, as you can see, of a lemon tint. She is very thin. There are a few subcutaneous hæmorrhages. There is a loud hæmic murmur and venous hum. The pulse is feeble; respiratory system normal. Both optic discs blurred. The case may be summed up as follows :—The optic neuritis became more marked. There was diarrhœa on March 24th, April 6th and May 2nd, and on these occasions the urine was particularly dark. One of these dark specimens I show you here. Otherwise she improved considerably. She took arsenic during the whole of her stay, and for some time large doses of β napthol, but this was left off as no improvement could be attributed to it, and it made her feel sick. Oxygen inhalations were tried without any good result. She left the Hospital on May 3rd but has come in again within the last few days.

State of the blood.—The following chart shows the quantity of hæmoglobin and red corpuscles. There is no excess of leucocytes :—

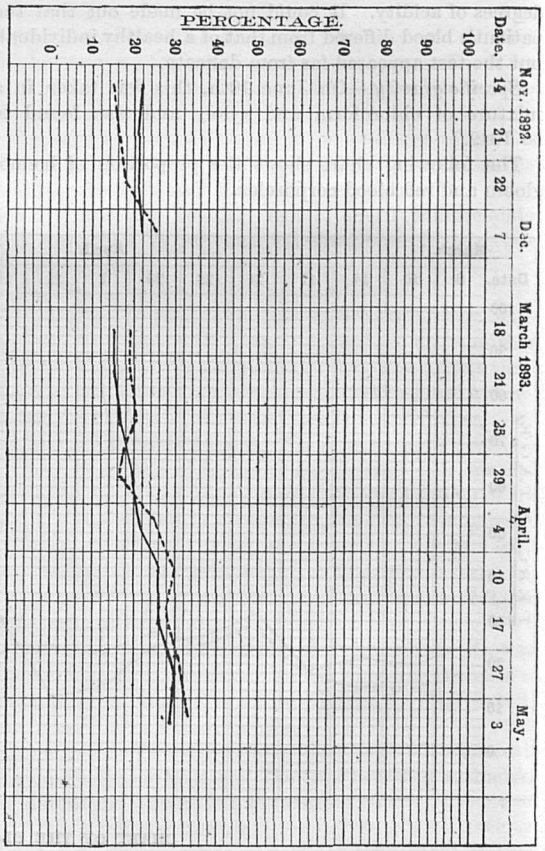


CHART OF THE BLOOD OF ANNIE GOODHART.

Black line ——— Percentage of red corpuscles.
Dotted line ------ Percentage of hæmoglobin.

The urine.—This was carefully examined every day.
Quantity.—Normal.
Specific gravity.—Almost always between 1010 and 1012.
Albumin.—On four occasions a faint trace was detected.
Bile.—None.
Indican.—None.
Colour.—March 18th–21st, high-coloured; 22nd, more highly coloured; 23rd–30th, high-coloured; April 1st–5th, light-coloured; 6th–8th, dark; 9th–11th, light; 12th, rather dark; 14th–22nd, light; 23rd–24th, rather dark; 25th–29th, light; May 2nd, dark. When the urine was dark the urobilin band was particularly broad, but there was never more than one band. This can be seen by looking at the specimen I shew you.

The temperature.—This was, as the annexed chart shows, raised during the whole of the patient's stay in the Hospital, and was on the whole a trifle higher than the first case. It was usually higher in the evening than the morning.

The urine, which I shew you, is rather dark, and a band of urobilin can be seen in the same position as in the other cases. Acid sp. gr. 1012. No sugar, blood or albumin. Urea, 1 per cent.

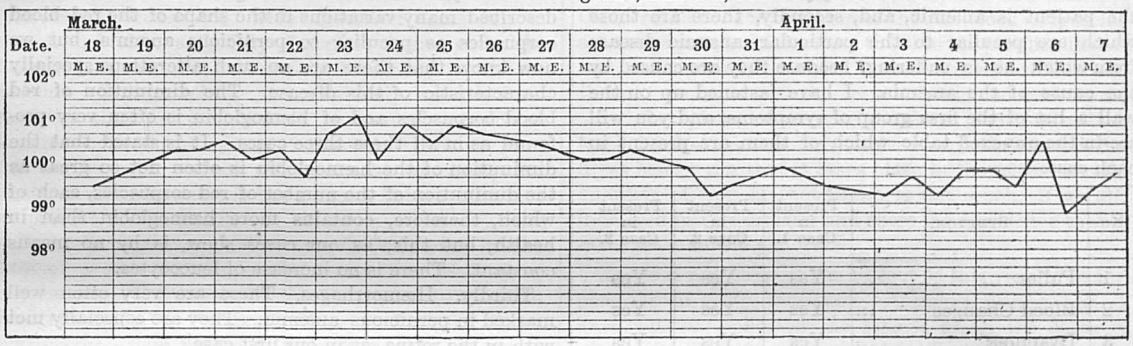
Blood.—Red corpuscles 20 per cent. Hæmoglobin 17 per cent. No excess of leucocytes.

Temperature.—This varies a fraction of a degree either side of 100.

An examination of the motions did not show them to be suggestive of ulcerative colitis.

Now the chief feature that all these cases have in common is that the anæmia is profound, and therefore it behoves us to consider what are the varieties of anæmia. They are—

(1) Anæmia secondary to some well defined disease or condition, such as severe hæmorrhage, severe long-standing diarrhœa as in ulcerative colitis, phthisis, syphilis, malignant disease, malignant endocarditis, exophthalmic goitre, malaria, etc.



CASE III.

Samuel Davis, aged 45, admitted December 23rd, 1893.

Family history.—Unimportant.

Personal history.—Is said to have had rheumatic fever twice, and dysentery at the age of thirty. Six years ago he had some severe illness which the doctor said was cholera.

Present illness.—In January, 1893, he had influenza, since which he has suffered from loss of appetite with occasional days of constipation and vomiting. Early in August, the symptoms being especially bad, he was treated by a doctor, and he improved, but lately he has been worse again. He has suffered much from weakness, palpitation, and breathlessness. Appetite poor. Occasionally his ankles have swelled.

Condition on admission.—He is very pale, with perhaps a slightly yellow tint.

Circulatory system.—He suffers from palpitation. The apex is very slightly outside the normal position. There is a soft systolic murmur at the apex, and a humming murmur in the neck. The lungs appear normal. The liver, spleen, and optic discs are normal. There is some headache, giddiness and buzzing in the ears. There are no enlarged glands. The rectum is normal. The bowels are open about twice a day.

(2) Anæmia *due to poisons, as lead and arsenic.*

(3) Anæmia due to parasites which suck blood, as ankylostoma duodenale and the bilharzia hæmatobia.

(4) Primary anæmia. This group is so called because we do not know the cause, but what evidence we have shows that it is due to some primary disorder of blood formation or destruction. These are (*a*) leucocythæmia; (*b*) Hodgkin's disease; (*c*) chlorosis; (*d*) pernicious anæmia; and (*e*) splenic anæmia.

Now, with regard to the diagnosis of the first two cases, we have had many opportunities of carefully examining the patients, and we could never find the slightest evidence that the anæmia was due to any of the first three groups, and, therefore, we were narrowed down to that of primary anæmia. Neither of the patients had any leucocytosis nor any enlargement of the spleen, and, consequently, they were not suffering from leucocythæmia; the absence of the enlargement of the lymphatic glands rendered Hodgkin's disease out of the question; the age of both and the sex of one negatived chlorosis; the fact that the spleen was not enlarged put splenic anæmia out of court, so that we were left with the diagnosis of pernicious anæmia.

With regard to the third case, the same line of reasoning renders it very probable that he has pernicious anæmia, but we must remember that the history of

diarrhœa renders it just possible that he may have ulcerative colitis, but I think this unlikely, for the diarrhœa has been too slight for the profundity of the anæmia, and the motions are unlike those of ulcerative colitis. Also, as the patient has been so short a time under observation it is possible that we may have failed to discover some obscure form of malignant disease or phthisis. It is very important to bear these two conditions in mind when thinking of pernicious anæmia, for they have often been mistaken for it. Lastly, when a patient, who has had rheumatic fever and who has a cardiac murmur, is anæmic and seriously ill, we should always think of malignant endocarditis, but in this case the duration of the illness is very much against such a diagnosis.

Now that we have arrived at a diagnosis, the next thing is to point out to you that you have in every case of anæmia two sets of symptoms to consider. First, there are those which are simply due to the fact that the patient is anæmic, and, secondly, there are those which are peculiar to the particular anæmic disease from which he is suffering, because they are caused by the cause of the anæmia. I have fastened up on the wall a list of the first group of symptoms, and you will see in the annexed table which of them are present in each case.

No.	Symptom.	Present in Case 1.	Present in Case 2.	Present in Case 3.
1	Pallor	Yes	Yes	Yes
2	Blood Changes ...	Yes	Yes	Yes
3	Dyspnœa	Yes	Yes	Yes
4	Hæmic Murmur ...	Yes	Yes	Yes
5	Bruit de Diable ...	—	Yes	Yes
6	Feeble Pulse	Yes	Yes	—
7	Palpitation of Heart...	—	Yes	Yes
8	Dilatation of Heart ...	—	Yes	Yes
9	Œdema of Ankles ...	Yes	Yes	Yes
10	Hæmorrhages	Yes	Yes	—
11	Optic Neuritis... ...	Yes	Yes	—
12	Headache	—	Yes	Yes
13	Giddiness	Yes	Yes	Yes
14	Buzzing in the Ears ...	—	Yes	Yes
15	Coma	Yes	—	Yes
16	Delirium	—	—	—
17	Dyspepsia	—	Yes	Yes
18	Constipation	—	—	Yes
19	Amenorrhœa	—	—	—
20	Rise of Temperature ...	Yes	Yes	Yes
21	Wasting	—	Yes	Yes
22	Weakness	Yes	Yes	Yes
23	Fatty Degeneration of Heart (P.M.)	Yes	—	—

You see, therefore, that these three cases present most of the symptoms which are diagnostic of anæmia, quite independently of the cause. Of those that are absent, some, as those connected with the circulation, would certainly have been present, had the patients not been kept quietly in bed, and the coma and delirium are especially characteristic of anæmia rapidly produced by large losses of blood.

Next, we have to enquire what are the symptoms special to pernicious anæmia. They are:—

Firstly. The colour of the pallor. This is usually of light lemon tint. The man who died shewed it admirably; the woman you have seen shews it very well, and the man to a much less degree. Careless observers mistake it for jaundice, a mistake that can at once be avoided by remembering that bile stains the conjunctivæ uniformly yellow. Associated with this lemon or primrose tint is a soft delicate looking condition of skin.

Secondly. The blood changes. Earlier observers described many variations in the shape of the red blood corpuscles as peculiar to pernicious anæmia, but we now know that there are no such alterations specially characteristic of this disease. The diminution of red blood corpuscles and of hæmoglobin is often very profound as in all these three cases. It is stated that the diminution of the hæmoglobin is often not so great as the diminution of the number of red corpuscles, each of which, therefore, contains more hæmoglobin than in health, but this, as our cases shew, is by no means constant. There is no increase of leucocytes.

Thirdly. Hæmorrhages. These are very often well marked in pernicious anæmia. They are especially met with in the retina, as in our first case.

Fourthly. Optic neuritis. This is more common in pernicious anæmia than in most forms of anæmia. Our second case shews it.

Fifthly. Rise of temperature. It is very characteristic of pernicious anæmia that the temperature should be slightly raised, usually it is about 100. All our cases illustrate this point.

Sixthly. Weakness. This is generally very great.

Seventhly. The urine. Much interest attaches to this, for it has been shewn that in the greater number of the cases of pernicious anæmia the urine is at some time or another in the course of the illness of a very dark colour, as you see in the specimens before you. This darkness is all the more remarkable, for in patients suffering from any other form of anæmia the urine is—unless there is some special reason to the contrary—pale, the degree of paleness corresponding roughly to the degree of anæmia. It is rare for the dark urine to be constantly present. Uusually, as in our cases, it is present for a time, and then the urine is pale for some days, and then it becomes dark again, and so these irregular alternations go on. This dark colour is due to a great excess of urobilin in the urine, and consequently there is a broad spectroscopic band between the blue and green parts of the spectrum, which can be seen in the specimens before you. For some time this colour was

stated to be due to pathological urobilin, and a three banded spectrum was described, but this Mr. Hopkins has shewn to be an error, the extra bands being due to the presence of hæmatoporphyrin in the urine.

Pathology.—Pernicious anæmia is a disease in which all of us who are at Guy's Hospital feel an especial interest, for it was Addison who first described it, and his recognition of it as a distinct clinical entity is one of the masterpieces of the art of clinical observation. Also the publication in the Guy's Hospital "Reports," by various members of the Staff, of an account of the cases that have occurred in the Hospital since Addison's time, has continued the work he began, and proved the accuracy of his original description.

Many physicians, and particularly some in Germany, have not fully grasped what is meant by pernicious anæmia. Addison for clinical reasons saw that it was, as he says, "a remarkable form of anæmia occurring without any discoverable cause." But it is quite clear that many writers who have described cases fail to understand this, and they describe severe chlorosis, hæmorrhage, etc., as ultimately becoming pernicious anæmia. This is totally and absolutely wrong. It is essential that for the case to be one of pernicious anæmia none of the causes of anæmia which we have put in our list should exist for the anæmia. No doubt pernicious anæmia has a cause, but we have not at present found it out.

Now, the first step, and a very difficult one, in the case of a rare disease, is the recognition of it as a clinical entity. Addison did this for pernicious anæmia. Hodgkin did it for Hodgkin's disease. Gull did it for myxœdema. The next step is to so advance our knowledge that we can prophecy that if the patient has, during life, this or that assemblage of symptoms, after death a constant characteristic condition will be found at the post-mortem.

During the last few years this advance has been made in the case of pernicious anæmia; and now if you diagnose this disease during life, you imply that at death it will be found that the quantity of iron in the liver is greatly increased; if at the post-mortem this is not so, your diagnosis was wrong, just the same as you would be wrong if—having diagnosed cirrhosis of the liver during life—when the patient died you found the liver was healthy.

The figures I have read to you shew that in our fatal case there was about twelve times as much iron in the liver as normal. The excess of iron is easily demonstrated at the post-mortem, either by treating the organ with sulphide of ammonium, when it turns black, or by dipping it in a mixture of ferrocyanide of potassium and very weak hydrochloric acid, when it turns a fine blue colour, owing to the formation of Prussian blue. This is beautifully shown in the sections under the microscope, and in the piece of liver you see before you. Sometimes if the increase of iron in the liver is not great, the Prussian blue does not shew well till sections are cut and examined microscopically, when it is found most abundantly in the hepatic cells of the outer two-thirds of each lobule.

If, as in this case, the increase of iron in the liver is very great, some increase may be found in the spleen and kidneys, but it is never anything like as great as in the liver.

The next question is, How does this iron get to the liver? As it is so abundant in this organ and yet is probably not formed there for it is found only at the periphery of the lobule, it is fair to assume that it arrives by the portal vein, which would explain why it is in the periphery of the lobule. Consequently the following very plausible hypothesis has been put forward. There is somewhere in the wall of the gastro-intestinal tract a great destruction of red blood corpuscles, this explains the anæmia. The iron resulting from the destruction is stored up in the liver; sometimes, if the amount is very great, some gets carried into the general circulation, and is met with in the spleen and kidneys. Other results of the breaking of the red blood corpuscles are the pigment which stains the skin the peculiar lemon tint, and the urobilin which darkens the urine. It is not thought probable that the destruction of the red corpuscles takes place in the cavity of the gastro-intestinal tract, for free iron would not be absorbed, nor are the fæces black; nor that it takes place in the spleen, for the quantity of iron in that organ is not much, if at all, increased in this disease, and there is no evidence that it takes place in the pancreas.

To see if any support can be lent to this view from the presence of gastro-intestinal symptoms during life, I have carefully collected the reports of all the cases of pernicious anæmia we have had in Guy's since the time of Addison. The result * was that 41 per cent. gave a history of vomiting before admission, and 34·5 per cent. gave a history of diarrhœa. After admission 55 per cent. suffered from vomiting, and 41 per cent. from diarrhœa. Cases in which the vomiting and diarrhœa might be due to arsenic are not included in these figures. Therefore an analysis of our cases, to a certain extent, supports the view that the seat of the blood destruction is in the wall of the gastro-intestinal tract.

Prognosis.—In order to gain information on this point, I followed up cases that had been in Guy's and had been discharged as improved. An analysis of the results shows that sometimes the patients die in the course of a few months from the onset of the disease, as in our fatal case. A very common thing is for them to get very much better under treatment; then they relapse after a few months of fair health again to get better under treatment. This alternation is very well seen in the woman I have shewn you. The usual end is for the second, third, or fourth relapse to be exceptionally severe, and for the patient to die in it. Recovery is very rare, still it does occur, and I have known two instances of it. One patient, though feeble, was well eleven years after he first came under observation. The other

* Guy's Hospital Reports, Vol. xlvii., p. 149.

patient four years after he was first seen was in robust health. To sum up, we may say that the prognosis is exceedingly grave, and you must be especially careful not to take too hopeful a view of the case because the patient improves under treatment, for in all probability he will soon relapse.

Treatment.—Every observer is agreed that the one only known treatment which will do any good and help to stave off the end is arsenic in full doses, taken immediately after meals, together with, if the patient is anything beyond quite a mild case, complete rest in bed for a time. Iron has often been tried, and it does more harm than good, for it upsets the digestion and does nothing towards improving the anæmia. I had an opportunity of demonstrating this in the wards some six years ago. On the supposition that possibly the cause of the breaking up of the blood in the portal area was some micro-organism, intestinal antiseptics have been tried, without, however, any good result. You will remember we could not make out that the woman you saw was any better for taking β napthol, one of the most powerful intestinal antiseptics.

Physical Society.

THE seventh meeting of the Physical Society was held in the Library on January 6th, when Dr. Bligh was in the chair. Thirty-six members were present.

The following clinical cases were shown:—

1. A case of occupation neurosis in a patient who earned her living by artistic embroidery. By Mr. J. W. Harris.
2. A case of progressive muscular atrophy in both upper extremities. By Mr. A. V. Clarke.
3. A woman suffering from ataxic paraplegia.
4. A child affected with post-diphtheritic paralysis. Both by Mr. Muncaster.
5. A man subject to paroxysmal hæmoglobinuria. By Mr. H. A. Moffat.
6. A boy with an exostosis of the right tibia. By Mr. J. C. Constable.
7. A child with tuberculous disease of the tarsus. By Mr. J. W. Sweetlove.
8. A man with an aneurysm of the right popliteal artery. By Mr. T. S. Biggs.
9. A child with infantile paraylsis of both legs and one arm. By the Chairman.

A brisk discussion then ensued, in which the following took part:—

With regard to the case of occupation neurosis, Mr. H. M. STEWART enquired whether the limb had been treated by means of absolute rest of the part, or physiological rest by leaving off the embroidering.

Mr. HOWARD thought the condition might be caused by peripheral neuritis, and hence suggested the application of galvanism.

Mr. HANDLEY considered that Mr. Howard's view was borne out by the fact that tenderness existed along the course of the nerves.

In discussing the case of ataxic paraplegia, Mr. G. S. HOVENDEN enquired as to the condition of the knee-jerks while the patient was in St. Mary's Hospital, and also whether the disease was at all connected with the previous fall upon the ice.

As regards the case of diphtheritic paralysis, Mr. STEWART enquired what was the usual cause of death. Mr. HANDLEY had seen two cases in which death had been caused by suffocation during the ingestion of food, and suggested that such cases should be fed by means of œsophageal tube. Mr. PAKES had watched this case, and had observed that the paralysis of the vocal cords had preceded that of the soft palate. There had been no anæsthesia of the palate.

In speaking of the case of hæmoglobinuria, Mr. PAKES enquired what the composition was of the granular *débris* which settled from the urine.

Mr. A. SALTER considered the case to be of a neurotic origin, and likened it to some cases of sanguineous sweating which he had heard of; its frequent association with gangrene of the ears and finger-tips bore out this theory.

As to the case of exostosis of tibia, Mr. SALTER enquired whether exostoses ever occurred elsewhere than at the epiphysial lines.

As to the case of tuberculous disease of the tarsus, Mr. E. COLEMAN asked whether the case had been treated by grey powder and cod-liver oil, as he had seen marked good effects by the above treatment in similar cases.

Mr. W. J. HARRIS wondered if the case Mr. Coleman had seen had been treated by rest as well, since he considered that this was the most important point in the treatment.

Mr. HARDENBERG suggested that scraping and the application of sulphur should be tried.

As to the case of popliteal aneurysm, Mr. HOVENDEN asked if digital compression was going to be tried, as he had no very firm belief in the efficacy of this treatment.

Messrs. PAKES and E. COLEMAN mentioned cases in which cure had been produced after 12 hours' application of digital compression.

The meeting was prolonged till past ten o'clock, and then adjourned.

Acknowledgments.

Antiseptics in Midwifery. R. Boxall, M.D. (London: H. K. Lewis.) 1/-.

The Indian Medico-Chirurgical Review.

Hygiene.

The Medical Pioneer.

The Hospital.

Passim.

IT is again our pleasant duty to congratulate Mr. A. Allport on having attained the honour of playing for his country in the football field, and everyone will be certain that our worthy friend did his fair share—and, possibly, more—of the excellent work which enabled England to claim such a magnificent victory over Wales last Saturday.

INFLUENZA and bronchitis have recently been playing havoc in the Medical Office, and their ravages have put a tiresome check on the large amount of business always awaiting transaction at such times as this.

GREAT was the applause when Mr. Lucas, on the 4th instant, again walked—or, rather dragged himself—into the Anatomical Theatre. Everyone was delighted to see him, many for the first time, and all admired his pluck and energy in so soon returning to his arduous duties while still laid low by his late illness, of the effects of which he still bears all too evident signs. Complete and speedy recovery say we all.

CHRISTMAS in the wards seems, from all we hear, to have been a very happy and exhilarating occasion, but the jollity has extended, apparently, even to the gates of the Hospital, for soon after our return, we noticed that one of the winged beings over the front gate had taken up a position anything but elegant or seraphic, and which much belied the motto written underneath her:

"Dare quam accipere."

Time has not in this case cured the evil.

MANY are the witnesses of operations just now, when the seats are thronged by the newly-entered, but the crowd has been considerably augmented by the presence of an inquisitive and inquiring band, who attended to see the further precautions against sepsis which Mr. Lane has adopted for himself and his dressers.

PERSONAL observation is to us still a pleasure of the future, but we hear that by everyone, —except the anæsthetist—in the well of the Theatre, white closely-buttoned mackintoshes are worn, stretching from the neck to the heels, and having short arms—over these is put on a brown holland coat wrung out in one in twenty carbolic, whilst careful washing of the hands and arms is as heretofore demanded. This is a double advantage, as it tends more effectually to obviate the carriage of germs into the wound and will aid the tidy man in his toilet, as a blood-spurted shirt-front will become a thing of the past. We hope soon to see such precautions —innovations here, though quite archaic in some other theatres—becoming general and even exceeded.

WE learn that owing to the continued inability of W. I. Hancock to take the field as Captain of the Football XV., M. P. Jones has been appointed at a meeting of the team to act in that capacity on the field.

A FACT. Brown and Jones discovered talking in the Colonnade—both being recently appointed dressers to Mr. Smith.—Enter Robinson, their H.-S.

Robinson, loquitur: I say, Brown, whose case is No. 21, Jacob?

Brown: Oh, it's Jones'.

Robinson: Well, look here, Jones. He is to be operated on this afternoon, and so you must shave and wash and clean him up (departs hurriedly).

Jones (his mind being full of the recent increased antiseptic precautions): Well, Brown, I do think it is coming it rather strong to be made to shave before going to dress at an operation (and he couldn't see why Brown laughed).

Hospital News.

In the Surgical Wards.

UNDER MR. DAVIES-COLLEY.

LUKE 15.—W. H., æt. 30. Was admitted on the 5th January, for pulsating swelling in right popliteal space. Three weeks ago he was caught by a barge rope round the leg and thrown overboard. Had no trouble until a week ago, when he noticed a swelling behind the right knee.

On admission.—There is a hard pulsating swelling 1½ inch by 1 inch in size. On compressing the femoral artery in the thigh the pulsation stops. On placing the two fingers of each hand above and below the swelling, the fingers are felt to be pushed away from the swelling, *i.e.*, upwards and downwards. A bruit can be heard through the stethoscope.

LYDIA 9.—A. F. G., æt. 4 months. Was admitted on the 5th January, for a large fluctuating swelling on right tibia. Patient's father has sores all over his body, which become white on scratching, and then go down. Mother has a sore on one of the alœ of her nose.

Mr. Davies-Colley made an incision about one inch in length over the swelling and let out about ʒss. of pus. There was no bare bone. Diagnosis?

In the Medical Wards.

UNDER DR. PYE-SMITH.

PHILIP 25.—Rheumatic Fever, Mitral Regurgitation, Erythema Marginatum.—F. A., æt. 8. Admitted October 31st, 1893, with a history of being very cold three weeks before, after a bathe, following which patient seemed out of sorts for two weeks. A week before admission, pain in ankles and right wrist appeared, and fever.

On admission.—Temperature 103, pulse 120, respiration, 32. Right wrist and both ankles hot, swollen and painful on passive movement. A faint apical systolic bruit was heard. Respiratory and urinary systems normal. Patient was put on milk and treated with salicylic acid, and in a week's time the temperature had gone down, the joints were normal, and there was no bruit, and he was put on farinaceous diet on November 7th. On the 10th he had a slight relapse, the hip and bursæ being affected. By the 21st all pain and swelling had disappeared, but a systolic apical bruit had appeared. Since this he has had two or three slight relapses, the temperature going up, but no swelling or pain of joints. On January 7th well-marked erythema marginatum appeared on abdomen, and is still there. There is also a well-marked apical systolic bruit.

PHILIP 22.—Rheumatic Fever—Sudamina.—P. R., æt. 26. Admitted December 29th, 1893, with a large number of joints swollen and painful, a high temperature, and all feverish symptoms. He had never had rheumatic fever before, and the present attack dated to three weeks back, commencing with a severe cold. He had sweated profusely before admission, and there was a thick sudamina all over front of chest and abdomen and neck, where it was marked best of all in the fold beneath the jaw. There was free desquamation over both arms in the form of white scales, up to the size of a threepenny-piece. The legs were free from sudamina or desquamation. The hands and feet were quite free. By January 3rd the temperature was normal, and there was stiffness of the joints only, but on the 4th he had a relapse. The desquamation has gone on to neck and chest. The possibility of scarlet fever was suggested, on account of the sore throat, the rash (which had appeared a week before admission), and the desquamation, but the subsequent progress of the case has gone against this.

MARY 37.—There is no history of phthisis or syphilis. She complained on admittance on December 29th, 1893, of pain in right side of chest. She is married; three children. Had pemphigus lasting for three years when about 36 years of age. Menopause occurred about two years ago. There is a history of a severe sore throat two years since, followed by great loss of power in the limbs. There also seems to have been some paralysis of the palate and ocular muscles. There is impaired movement of right chest, some tenderness over the apex in front; dulness both in front and behind, below the second rib in front, the fourth behind; the breath sounds are audible all over chest, though much diminished on the right. On January 8th, bronchial breathing was heard behind. Some râles and rhonchi have been heard, but only rarely. The voice sounds on right behind are nasal and generally diminished, though about the ninth space increased. There has been slight dyspnœa; patient brings up very little sputum. The circulatory system is normal; there are distended veins over chest and abdomen, and both upper arms. The abdomen is normal. She is very neurotic. Temperature is normal or subnormal. She is taking ipecacuanha and squill. There is some peripheral neuritis.

On 8th, at 7.30 p.m., extreme dyspnœa came on, with cyanosis. Heart beat found in axilla; 52 ounces of serum drawn off from right chest. Relief, but died suddenly two hours later.

Abstract of Autopsy.—There was 24 ounces of fluid in right chest; glands below and between bronchi normal; glands to right of trachea, above bronchus, form a large and succulent growth, caseating in many centres. Growth measured five and a-half inches vertically; two inches antero-posteriorly; four inches transversely; lies anterior to trachea, and slightly to the right, adherent to and invading apex of right lung; in the centre are the pigmented remains of glands, and several caseating centres. Left lung engorged with blood; muco-pus in bronchial tubes.

Pleura.—Right, covered with lymph, the lung being compressed by fluid; deficient in air; upper lobe has

several soft masses of growth. Left, innominate vein thrombosed; clot firmly adherent; duration about a fortnight; right, internal jugular patent, but there is recent thrombosis in the left one.

Pericardium contains blood-stained fluid; growth just extended into its upper part; adherent over the aorta. Superior Vena Cava surrounded by growth, not thrombosed.

Heart.—Small; free from growth; weight, 7 ounces. *Thyroid* slightly enlarged. Recurrent laryngeal nerve passes through growth. *Spleen* normal; 2½ ounces. *Kidneys* normal; 8½ ounces; small fibroma on cortex. *Stomach* normal. *Liver* 40 ounces, normal.

PHILIP 21.—W. H., 31., warehouseman. Patient was in for nearly three months last summer under Dr. Goodhart, coming in for pain in abdomen and retching. There was an abdominal aneurysm; and patient was somewhat relieved. At this time there was no albuminuria. Went out September 13th; re-admitted under Dr. Pitt into Philip 21 on November 26th, 1893. There is a distinct history of a specific sore, followed by a rash, four years ago, and there are large glands in both inguinal regions, and ulcers beneath tongue.

On re-admission for vomiting, pain and constipation, patient was in a very drowsy state, and the day after admission epileptiform convulsions took place. There was albuminuria (22 per 1,000) due, Dr. Pitt suggested, to thrombosis of, or pressure on, the renal vein. There are no casts, there is no œdema, the retinæ are normal. His mental condition has improved gradually, and is now normal. The aneurysm remains in same state; he has some vomiting almost every day. Albuminuria is now 4 per 1000.

UNDER DR. TAYLOR.

MARY 40.—C. M., æt. 9. Admitted on December 21st, 1893, with cough, wasting and pain in chest. Father died of phthisis. Patient had pertussis when a baby: was admitted into London and South Western Railway Orphanage on September 14th, 1893; looked delicate, but no phthisis was made out. Patient kept much to herself, had slight anorexia. Cough set in in early part of October. Diarrhœa three weeks ago, also diarrhœa one week ago. Frontal headache for last three weeks.

On admittance. — Temperature, 99·4. Pulse, 160. Respiration, 60. Patient is anæmic; wasted; skin dry; cough dry and troublesome; no impairment of chest movement or resonance; air enters well; lengthened expiration in supra-clavicular spaces. High-pitched breathing on back of left chest, between scapula and spine, over fifth space and sixth rib, about three inches from middle line; voice sounds slightly increased over this area, also on back of left chest above this area. Cardiac dulness extends from lower border of third rib to upper border of fifth.

December 22nd.—Flushed face; fine clicking râle at end of inspiration over front of left apex down to second rib; also behind, scattered over right lung, especially at base. At right base there is impaired entry of air with slight tendency to bronchial breathing. Temperature, 101.

23rd.—Anæmic again. Temperature, 102·2. Skin hot and dry.

28th.—Resonance slightly impaired below left clavicle down to upper border of second rib, also behind over left supraspinous area with deficient entry of air. Fine clicking râles at left apex in front and right base behind. Temperature, 101·8. Pulse, 120. Respiration, 28.

January 4th.—No râles.

6th.—Râles at base of left lung. Abdomen full and tense.

Diet, full. Mist. Oxymellis Co. ʒiv. t.d.s.

STEPHEN 13.—M. E. C, æt. 48. Admitted December 12th, 1893, for tabes dorsalis.

Patient had morbilli and pertussis when a child. Rheumatic pains in arms and legs for last nine years; otherwise healthy up to April, 1893. Patient three years ago found he could not see on extreme right when looking at an object in front of him; quite recently he has noticed the same with regard to his left. Patient is moderate drinker. No gonorrhœa; no syphilis.

Since January, 1893, numbness, cramps, pins and needles in legs. In April, 1893, patient got wet one night, went home, fainted, was unconscious seven minutes; after this found legs very weak and full of pins and needles. Patient stayed in bed five weeks, then spent summer at seaside, walking and bathing a good deal. September, 1893, patient was unable to walk or stand in dark—would get giddy. Legs now got ataxic, and patient could walk only on level ground in daylight. August, 1893, patient had sense of "weight" about stomach, which developed into "ataxic" belt. Since faint in April, lightning pains in arms and legs—worst in damp weather. For last five weeks, stream has been weaker, but no incontinence. Legs have been wasting lately.

Condition on admission.—Knee-jerks, ankle cloni, and plantar reflexes are absent; tactile sensibility unimpaired; analgesia on front, inner and outer sides of legs, from ankles to knees; sensibility to pain sluggish on ankles and feet; diminished power to distinguish heat and cold also between ankles and knees, especially on inner sides; sensation to cold intensified on arms. Dynamometer—left hand, 70; right hand, 90. Muscular sense impaired, does not know position of legs unless looking at them; cannot place legs where he wants to. Pupils contracted, left the smaller. No reaction to light. Right reacts slightly to A.C.C.,—not the left. Perimeter—limited field of vision of right eye, except on outer side.

During last four years all teeth of upper jaw—except incisors—have become loose and were then pulled out by patient.

Dr. Taylor saw patient on 14th: said the right optic disc was white with some atrophy, and thought patient had some adductor spasm of legs. Patient cannot walk nor stand by himself.

January 8th.—Patient can walk with the aid of locomotive chair; seems to have very little control over legs, and crosses them whilst walking. Patient can stand by himself until he counts forty.

UNDER DR. GOODHART.

PHILIP 10.—K. B., æt. 48. Admitted December 18th, 1893, for left hemiplegia.

History of present condition.—On December 17th, patient went to bed quite healthy, and he got up shortly after to make water, when his left leg gave way, and he found his left arm helpless.

Condition on admission.—Paralysis of all left side. Left side of face blank. Right side of mouth drawn upwards. Anæsthesia and analgesia on left side. Bladder and rectum normal. Heart normal. Radial arteries very much thickened and cord-like to the touch.

In this case the age and condition of the arteries point to hæmorrhage.

PHILIP 8.—Schoolboy, æt. 10¾ years. Admitted December 9th, 1893, for chorea. No history of rheumatism.

On admission.—Chorea. No bruits heard.

December 13th. Accentuated first sound, short sharp second, and distinct mid-diastolic at apex.

27th. Systolic bruit and mid-diastolic, but patient much improved.

January 1st. Suddenly this morning patient became comatose. Face and eyes turned up towards right side. Left side and left side of face, paralysed. Both knee-jerks absent. Ankle clonus on left. Plantar reflexes well marked right, slight left. Fed by nasal tube, unable to pass stomach tube. Pupils dilated, and react to light. In crying both sides are symmetrical. Can shut eyes. Cutaneous reflexes on right side of abdomen well marked, absent on left. Temperature 101.

The diagnosis in this case is embolus following endocarditis.

PHILIP 9.—J. H. F., æt. 27. Admitted December 16th, 1893, for paralysis and aphasia.

Personal history.—Good, except for syphilis two years ago.

History of present condition.—On October 14th, 1893, patient suddenly lost power over right limbs. Not unconscious. Five minutes after attack able to walk. Patient improved much.

December 14th. Right angle of mouth drawn up. Twitchings of muscles. Speech thick.

15th. Apoplectic seizure. Unconscious half an hour. Right arm and leg paralysed.

Condition on admission.—Crossed hemiplegia. Left side of face and right arm and leg paralysed.

On attempting to whistle.—Lips in contact on left side of mouth, not in contact on right. Fossa under nose displaced to right side.

Tongue cannot be protruded at all.

Speech.—Voice completely lost. Can only whisper "Yes" or "No" very indistinctly.

Deglutition.—Patient cannot swallow, has to be fed with a stomach tube.

Sensory.—Quite conscious, and understands questions. No anæsthesia.

Hearing lost to some extent on right side.

Breathing nearly entirely diaphragmatic.

Reflexes.—Knee-jerk present both sides. Left exaggerated. No ankle clonus. Patella reflex present on left.

This case is probably one of thrombosis due to syphilitic endarteritis, the lesion being situated in lower part of the pons below the crossing of the facial fibres, and above the decussation of the pyramids.

UNDER DR. HALE WHITE.

G. T., æt. 20, parlour-maid. Admitted, December 27th last, for pain and swelling of abdomen. Three weeks ago had aching pain in her back, and noticed that her abdomen was somewhat swollen. Swelling has gradually increased ever since. The last fortnight she has noticed pain in lower part of left chest when lying on left side.

On admission.—Temperature 99·6 (? 100), respiration 28. Physical signs of fluid in abdomen and left side of chest. Circulatory system and urine normal. Bowels constipated.

Treatment.—Mist. Copaibæ Resinæ ʒi. t.d.s. Ung. Hydrarg. Oleati p. a. on abdomen.

January 4th. Yesterday evening patient had red spots coming out on abdomen (where ointment was applied), and over elbows and forearms. During the night rash broke out over whole body, most marked over face, arms, abdomen, back and thighs, less marked over front of chest, legs and feet.

Character.—Red spots slightly raised above surface, and coalescing together to form irregular erythematous patches, accompanied with itching.

5th. *Face.*—The patches have coalesced and the cheeks have a dark-red bloated appearance.

Back.—All over the back, most marked at its upper part, the rash has a petechial character, very similar to measles rash.

Front of chest and abdomen covered with irregular erythematous patches, thicker on abdomen.

Arms have much the same appearance as the face. Palms not affected.

Legs.—The rash over the inner side of right tibia has a decided urticarial character, the spots being larger and more raised than those on chest. They are red in colour. Similar spots on lower part of front of left leg and dorsum of left foot.

Feet.—Dorsum covered with red spots. Plantar surface and toes not affected. There is little desquamation over the face, middle of back, and left leg. Temperature yesterday up to 103, to-day 102. Throat is a little reddened upon left side. Patient complains of it being sore.

6th.—*Face and Arms* much less red. Little desquamation over face.

Legs.—Outer surfaces of legs desquamate a little. Skin in this region rather scaly and shiny. Spots on inner surface of right leg have lost their urticarial character.

Back, chest and abdomen are in the same condition.

Feet.—Dorsum covered with red spots, which itch a good deal.

MARY 1.—E. H., 55. Admitted, November 15th last, for growth in umbilical region of abdomen. Has not been

well for two years, suffering from indigestion and irregularity of the bowels, and has lost flesh. Three months ago discovered a small lump above umbilicus. Has been sick several times, and brought up blood once or twice.

On admission.—Does not look very wasted.

Abdomen.—Distinct fulness above and to right of umbilicus; swelling moves with respiration: is rather superficial, hard and nodular, oblong, tender to palpation, especially at right end; reaches one inch below, two inches above, and four to five inches on either side of umbilicus. Since admission, patient has been sick almost daily. Vomit does not give HCl. reaction. Small quantity of blood has been found in it once or twice.

December 12th. Patient went out much in same condition as on admission, but having lost eight pounds in weight, and growth being slightly larger.

27th. Patient re-admitted. Gained one and a quarter pounds while away.

Poisoning by Nicotin.

THE following notes from my case book, slightly expanded of course, afford a striking example of the awful precocity of the rising generation, and also of the poisonous effects of the soothing weed.

Surely in these days of Royal Commissions attention might be diverted (for a while, at least) from drugs such as opium—of which the B. P.* in general knows very little, and the cranks in particular still less—to such a crying evil as the act of disguising the common or garden cabbage in a piece of the leaf of *Nicotiana Tabacum* and calling it a cigar—an article of commerce which only too frequently proves "a wolf in sheep's clothing," as Shakespeare or somebody else remarks.

While acting as a *locum* recently, I was called out one night just before Christmas to attend "Mrs. B——'s little Billy" in a small slum in Southwark. Duty was, of course, at a premium, so five minutes later found me trudging through the mud by the side of a typical Borough "lidy" ("i" long, if you please).

My numerous queries elicited the following facts:—Little Billy would be five years old come Sunday week, and was a proper demon for smoking, going systematically through his father's pockets every night to steal tobacco. That very evening he had smoked a cigar right through, to the intense amusement of the assembled crowd. This occurred at 10 p.m. The boy was not sick, but at 11.30 became unconscious, and "looked for death"—my informant didn't say where, but anyhow it seemed an unnecessary display of energy on the lad's part.

On arriving at the house, the door was opened by Mrs. B——, who, after treating me to a prolonged stare, uttered a piercing shriek and, accompanied by the draggle-tailed and down-at-the-heel Mercury, rushed out into the darkness of the night. (It strikes me I have seen a sentence like that last in some shilling shocker, but I'll let it stand.)

In the back kitchen I found Mr. B—— in bed, and in liquor. He proceeded in a most playful manner to drag the patient from under the bedclothes, explaining meanwhile that it was all his fault; he had determined to cure the boy of his evil habits, so placed the cigar in his way—a cigar purchased especially for the occasion, he knew it was a good one, for it was quite black and had yellow spots all over it, and it cost him twopence, and the man gave him an empty cigar box into the bargain, etc., etc., etc.

I managed to cut this loquacious father short by sending him to get some hot water and light the fire, so gaining sufficient breathing time to examine the child.

The little patient was collapsed and quite unconscious—shaking, or shouting in his ear, failing to rouse him. The face was quite white, the lips cyanosed and the teeth firmly closed; while the muscles of the neck, trunk and extremities were flabby and relaxed.

The surface of the body was cold, the temperature in the rectum being 97° F., at the same time that an Immisch's watch thermometer in the axilla registered 96·6° F. The pulse (66) was small, feeble, and irregular; the breathing stertorous, the respirations numbering twelve per minute.

On examining the eyes, the pupils were found to be unequal (the left much contracted, the right less so) and fixed—refusing to react to light.

The treatment I adopted was the hypodermic injection of $\frac{1}{15}$ gr. apomorph. hydrochlor.

After waiting a minute or two, the mouth was kept open by means of a stick of firewood held between the jaws, the fauces then irritated by the tip of my forefinger. Vomiting having been thus fairly started, the stomach was well washed out by the alternate ingestion and rejection of large quantities of tepid salt water until the vomit ceased to smell of tobacco. The patient was then well wrapped up in a warm blanket and hot sand-bags from the window and beer bottles full of hot water packed round him.

Next a cup of strong, hot coffee was administered, followed at an interval of about five minutes by Mist. Ammoniæ ℥ss.

By this time the patient was quite conscious, the pulse and breathing had improved, and the temperature in the axilla was 97·8° F.

On visiting this juvenile smoker the following afternoon, he was found to be completely recovered, and although looking pale, was running about in fairly good spirits.

J. C.

DREAMS OF REVENGE.—(Time: After a taste of the cane). *Schoolmaster:* "You're the worst boy I ever saw. You'll never be a man." *Small Boy:* "Ugh, I don't want to be a man." *Schoolmaster:* "Eh? What do you want to be then?" *Boy:* "A microbe."

* The British Public, *not* the British Pharmacopœia.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Dressers' Lockers.

SIR,—As an assistant-surgeon's dresser, the student has the right to make use of one of the very excellent lockers near the library, but when he attains to the state and dignity of dresser to a full surgeon, he receives from the librarian notice to quit. The dressers' room, supplied as it is with every home-comfort, is supposed to suffice for his needs. Strange as it may appear to you, sir, encased in thick armour of integrity, property has occasionally been lost when left to this room's safe keeping. Could not lockers be provided for the use of the dressers? There is ample room for such, in place of the crazy furniture and dusty cupboards which form at present the sole accommodation for the unhappy dresser.

DISTRESSED LEUCOCYTE.

Uncovered!

SIR,—It was with some concern that I read the following in a letter just received from a country friend:—"Among all the distressing spectacles which I witnessed in the course of my visit to London during the recent Arctic weather, nothing caused me greater pain than to see, at one of the great London hospitals, young fellows whom I at first surmised to be members of the unemployed, but afterwards learnt were students, going about in the open, hatless, insufficiently clad, with hunger plainly written on their drawn faces. Is it not a reproach on our Christian civilisation that these brave fellows, in their self-forgetful search for the knowledge of how to relieve the sufferings of others, should themselves be the victims of want and exposure? The medical student—as I saw him—is, indeed, a different being to those we read of, and it only shows how little the world knows, and how careful we should be not to hastily judge those who, on nearer acquaintance, turn out to be so much nobler than ourselves. Cannot something be done, however, to alleviate the present distress in the way of a soup kitchen, and the distribution of warm clothing? If so, I shall be glad to contribute, and will try and interest all my friends down here in so good a cause. Please let me have your view."

Now, this places me in a pretty fix. If I tell my friend the truth, his faith in human nature will be shattered, and I shall lose his friendship for my pains. If, on the contrary, I refrain, your Medical School will be scandalised by receiving doles of soup and old overcoats. But this would only serve the members of the Medical School right for unnecessarily parading themselves as sham spectacles of abject misery, and imposing on the generosity of unsuspecting people. Whatever may be the real reason for the custom which deprives the student of proper covering, it cannot survive twenty degrees of frost. Young gentlemen once within the precincts of the Hospital may affect to be superior to atmospheric conditions, but their looks belie them, and if they have no regard for their own feelings, they might remember those of others. It is exceedingly unpleasant to be surrounded by persons with blue noses, chattering teeth, and shivering bodies. What would their mothers say were they to see their sons discarding the hats and overcoats, the outcome of parental care and expenditure, and what respect can be paid to those who, while professing to be students of science, disregard the first law of nature? The scientific enthusiasm which renders men oblivious to personal considerations is all very well, but the torch of science must have been very nearly falling from the numbed fingers which held it recently. I would not have it thought that I am in any way advocating a reform. To do this, in dealing with medicals, would be fatal to the purpose, and they may go naked so far as I am concerned, but I should like to know what reply to return to my friend.—Your obedient servant, X.

From the Gazette's Special Pathologist.

S. W. M. I., SOUTH PETHERTON.—Vas deferens shows chronic catarrhal changes of epithelium, and tubercular inflammation of surrounding tissue. Epididymis is in a condition of subacute tubercular change with typical early tubercles. There is no caseous degeneration. The ulceration of tubes, connective tissue, and vessels is well marked.

G. R. P., FORDINGBRIDGE.—A few tubercle bacilli were recognised among a large number of micro-organisms.

J. B., NOTTINGHAM.—The specimen shews infiltration at the change of mucous membrane, and would deserve the use of the clinical term "precancerous condition," though no actual cancerous structure was observed.

PATHOLOGIST.

Specimens for examination and description in this column, should be addressed to H. HUNT, GAZETTE, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

The column is intended to be an assistance to practitioners who are unable otherwise to obtain histological or other descriptions of their specimens: these will be examined and reported on in the GAZETTE, but, in order that the work of professed histologists may not be interfered with, a fee of £1 1s., or in some cases £2 2s., must be paid before a *private* report of any specimen can be supplied.

AFTER THE OPERATION. — *Surgeon* (to Dresser): "Would you like, sir, to put in these ligatures?"

Dresser: "Yes, sir! yes, sir! Thank you, sir!"

Surgeon: "Then I will show you how" (finishes by putting in last stitch). "There, sir! Hand me the dressings."

Dresser: —— !* —— !* —— !*

Paper read before the Physical Society on the Value of Symptoms in Intestinal Obstruction.

BY MR. H. A. MOFFAT.

MR. PRESIDENT AND GENTLEMEN.—Only those who have enjoyed this honour can appreciate the diffidence with which anyone ventures to read a paper before our Physical Society, and when but a junior member does so, his mind must always be in a most perturbed and even confused state. It is rather a curious position, in which one without any real experience stands, with regard to such a purely clinical subject as this. By the aid of books, papers, teaching, and one's common sense, certain conclusions are arrived at which, so far as I am concerned, have yet to be verified by experience, yet I venture to put them forth to-night.

The importance of all signs of obstruction which may help to its diagnosis, and then of the kind and position, goes without saying. I have looked more at the symptoms chiefly to see how far we may be sure of the form and position of obstruction. In all forms the symptoms are almost entirely the same, differing only in intensity and in the time of their onset, and it is these particulars which it is so very difficult to obtain.

Dr. Fagge, in a paper in the Guy's Reports says, "the symptoms and course depend far more on the pathology of the lesion than on the seat; but it so happens that the majority of obstructions of the large intestine are by stricture, of the small by strangulation," so that we may say the symptoms vary also according to the site, though this is accidental.

It seemed to me that the symptoms might be considered under two heads, distinguishing the results of mere obstruction from the results of other lesions accompanying or causing obstruction. Obstruction is in itself a symptom or result of some lesion, and is always accompanied by other results of the same and of other lesions. The number and characters of the various lesions produces an immense field of symptoms with grades of all descriptions. Any one who likes to glance into Treves' book on Intestinal Obstruction will be bewildered by the variety of causes which are there classed and re-classed several times over. Though the division under these two heads is, maybe, very artificial—for the effects cannot be separated—yet it seems to make things clearer.

The effects of mere obstruction, complete or incomplete, are constipation, vomiting, distension, pain. The forms which would illustrate this are such as inpaction of fæces or of a gall-stone, where obstruction and very little else is produced.

Fæcal accumulations may go on to an enormous extent without giving any particular symptoms—obstruction of itself. There are cases on record, in England and France, as well as in America, of absolute constipation for eight months.

Mere obstruction does not produce an abrupt onset of pain or sickness, but a gradual increase in severity. This contrasts with the effect of strangulation.

The four symptoms of obstruction which Dr. Taylor gave in his clinical at the beginning of November: pain, vomiting, constipation, distension.

Pain.—This is termed colichy, "due to spasmodic contraction of the fibres of the intestine." The case given above does not shed any light. This kind of pain is known to each of us, but it is by no means definite. It must be distinguished from the other form of pain which occurs in obstruction sooner or later, though not due to the obstruction—namely, that caused by mechanical lesion to the intestinal wall, or to the peritoneum, or, as Dr. Pye-Smith says, perhaps to the disorder of circulation in part affected.

Brinton, who makes this distinction of the pains, ascribes the colichy pains to distension of the intestine just above the obstruction, and therefore only indirectly to the contractions; whereas Treves considers it directly due to the irregular and exaggerated peristalsis, of cramp. From the presence of pain, so far as we can judge, exactly similar in ordinary colic, Treves seems correct.

Continuous or not.—Treves makes rather a point of the intermittence or otherwise of the pain, and states somewhat decisively that in complete occlusion there is continuous pain, in incomplete occlusion intermittent, and that as the latter becomes more nearly complete, so the pain becomes less intermittent. I don't see why there should not be complete obstruction with only paroxysmal pain, but, as a general rule, complete obstruction occurs about the same time as injury to the peritoneum or intestinal wall, or, at any rate, this injury will soon follow complete occlusion.

For us the pain must be regarded as to whether it will show the nature of the obstruction and the position.

The intermittent or otherwise character helps us to decide the amount, so to speak; the nature and severity point to the obstructing agent. Of course, all pain is, to a certain extent, deceptive, on account of the individual differences of capability of bearing it; but still all seem to say that in strangulation by band, where there is severe injury to the peritoneal and other walls of the intestine, the pain is most acute; in intussusception it is less so, in volvulus still less, and in growth it is least. It will vary with the amount of gut involved, and at different periods of the case. At the beginning of a case of band strangulation it will not be paroxysmal with free intervals, but continuous with exacerbations, and Treves explains this by the obstruction being complete from beginning. Exceptions to this: Bryant's case of band attached to bladder.

In intussusception there are at first completely painless intervals, which are very characteristic. And again, at the last, when gangrene has set in, pain disappears entirely. But pain also disappears in all other forms as the collapse becomes pronounced.

So we may say: Continuous and very severe pain in acute strangulation; milder in volvulus, with better marked intervals; about same in intussusception, but intervals clear. In all chronic cases, pain not so severe, and with intervals of ease.

Position.—Small intestine is said to be more sensitive than large; and, even if that is not really so, acute obstruction and strangulation is generally in small gut.

As to being able to localise the pain, authorities differ. Treves says it is of no value, and is even apt to be misleading; others say that at first the localisation is quite correct. Treves holds that the pain is generally a referred one, and explains its position about umbilicus as being due to the position of the superior mesenteric and splanchnic ganglia here. He contrasts the intestine with the skin surface; the former always changing in position, and with no experience; in the colon and stomach our references may be more correct.

Tenderness likely to be more true. It is associated mainly with the development of peritonitis, local or general, the tenderness corresponding. Hence there is likely to be acute tenderness fairly early in volvulus; in intussusception also, but here pain is often relieved by pressure at first, and the subsequent tenderness may be explained by the peritonitis, or by the tenderness of the muscle of intestine which has long been in a kind of cramp. This tenderness is useful when distinctly localised. It exists also very often in stricture by growth.

Constipation varies with the completeness of the obstruction. Hence, in stricture of the intestine from growth, there is generally constipation for some time, with often intervals of diarrhœa. The slight variations observable are generally reasonably explained; in chronic and acute intussusception there is generally a tendency to diarrhœa from the movements set up by the intussusception acting as a foreign body. In chronic intussusception the bowels are most irregular, sometimes diarrhœa, constipation, or normal. Treves notes: "The only certain thing is their uncertainty." In growth of the large intestine there is generally constipation; in acute strangulation there may be a motion from the bowel below, but generally not. This Treves assigns to reflex nerve action, or rather inhibition of action.

Dr. Taylor, in his clinical, said that if only the obstruction lasted long enough the contents above it would become fluid, and this explains the diarrhœa after an attack of obstruction in growth.

Vomiting.—Herein lies a fertile field for battle as regards the cause. Before Brinton, the view was universally held that it was due to an antiperistalsis; but he shewed that fæculent vomiting could be explained entirely without a reverse peristaltic wave, by the fact that, with an obstruction, the contents of the intestine would tend to pass downwards at periphery, upwards at centre. This view again has been modified; thus, with occasional antiperistalsis and the action of the muscles of abdominal wall.

In all acute forms of obstruction, vomiting begins early and is severe, and soon becomes fæculent, except in volvulus of sigmoid and intussusception, when it is milder, may not become fæculent, and may even be absent. It seems to be dependent on amount of injury and position.

Vomiting is partially a reflex phenomenon; it is so in the rapid vomiting which sets in with acute strangulation. Mr. Bryant gives a rather interesting case, quoted by Treves, of vomiting after the formation of an artificial anus, from the irritation of fæces retained in the lower part of the bowel.

Other things being equal,—that is, injury to the peritoneum or intestinal wall—the onset of vomiting, and of the various kinds, will vary in rapidity, according to distance from the stomach. If the obstruction is in the upper part of the small intestine, vomiting is very severe, much bile, and it soon becomes fæculent in odour; if in lower part of large, the vomiting is slower in coming on, less severe, and takes some time to become fæculent. The contents of the lower ileum are fæculent, especially if abnormally retained. But in the jejunum, the contents—though of a fæculent odour—never becomes distinctly fæculent.

Fæcal vomiting is pathognomonic of obstruction; and in the various kinds of obstruction it is in diagnosis extremely useful. In the obstruction of the large intestine, the ileo-cæcal valve has first to become incompetent; this may happen in intussusception fairly readily (hence fæculent vomiting in 25 per cent.), in sigmoid volvulus the great distension aids it (hence in 15 per cent.), and in stricture of large intestine it will only occur after a very long time by the distension of the large intestine, and this very distension, if it leads to paralysis, will delay the onset of fæcal vomiting.

The cæcum generally bears the brunt of distension following obstruction anywhere below it; hence the valve would give way. Pain is hence often referred to cæcum.

Distension of the abdomen, due to the accumulation of gas in the intestine above the obstruction, varies a good deal. When it is extreme and has existed for some time the distension will be general, but at the onset of meteorism one would expect it to vary according to the position of the obstruction. Thus, that in an obstruction in the cæcum or ileum, the epigastric and umbilical regions would first become prominent; in an obstruction of the sigmoid, the colon would get marked out. Yet this does not seem reliable; the small intestines are always varying from one part of the abdomen to another, and the mobility of the colon and sigmoid vary. You will remember Mr. Symonds calling attention to this and to the visible coils sometimes seen; even these latter seem very misleading, much more so than we should expect.

(To be continued.)

Voces Populi.

SCENE: The Smoking Room.

Time 2.30. Room just emptying after its mid-day repletion.

Recent Entry (in the largest armchair before a large fire, with a small cigarette in a larger holder, Taylor's Med. Jur. by his side)—puffs: "Yes. I've seen a great deal since I came up a week or so ago" (puffs).

Chronic (with aged briar and *Pick-me-up*): "Oh, have you. What?"

R. E.: "Let me see. I saw the Dissecting Room the first day and went over the 'Pickle' Room. Then, of course, I went to Out-patients', where I was impressed with the importance of all Guy's men recognising a certain odour carried on a vaselined digit; also visited the P.M. Room and played with the water taps. Yes, I have been a pretty regular attendant in the Surgery, and I think the men there (!) have to thank me for teaching them how to quell the wailings of spoilt children, and how to overcome the obstinacy of hyper-sensitive matrons. But there were one or two men up there who interfered with me—a man, with scissors on the end of a chain, asked me to walk in the next room and take my trousers down, and his surprise and disgust were only too evident when I said that I was as much a Guy's MAN as he. At another time, they asked me to hold an arm which I imagined to be fractured, but evidently forgot my existence, for after half-an-hour one man said, 'Oh, Brown, lead and opium for that bruise,'—and my arms did ache so. I have given them up as incorrigible" (relapses into silent puffing).

Chronic (waking up from exhaustion following the perusal of a joke in P. M. U.): "Of course you've been into the Operation Theatre."

R. E. (as a matter of course): "Oh yes. I've seen three amputations, and a breast, a hernia, etc., etc. But, I say, I'm rather in the dark about those long white coats, for at first I thought I had broken in on a council of umpires, or a junior World's Water Show. What do they mean?"

(*Chronic* explains the mackintoshes with due reference to the march of asepsis at Guy's, and learns on enquiry that the *R. E.* has joined the Pre. Sci. classes.)

[*Silence reigns supreme.*]

Appointments.

BEARBLOCK, P. ESDAILE, M.R.C.S., L.R.C.P. Lond., has been appointed Assistant House-Surgeon to the Royal Albert Hospital, Devonport, *vice* A. C. F. Smith.

FARR, E. A., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Andover Urban Sanitary District of the Andover Union, *vice* E. B. Farr, resigned.

JONES, F. F., M.R.C.S., D.P.H. Camb., has been re-appointed Medical Officer of Health for the combined Sanitary Districts of the Llanfyllin Union.

Notice.

KINGZETT'S IMPROVED SULPHUR FUMIGATING CANDLE.

Mr. Kingzett's original sulphur candle consisted of a dish of sulphur having set in the mass a fuse moulded in the form of a cone. The fuse was composed of sulphur mixed with chlorate or nitrate of potassium or sodium. In the improved candle, in place of the sulphur cone, a strip of ribbon of Brussels' net or other similar material is used. This strip has been first coated with a thin layer of sulphur by passage through a bath of that substance in a molten state. The strips of sulphur-coated material are cut into suitable lengths, bent into circular form, and then placed in the molten mass of sulphur forming the body of the candle. On application of a light to the prepared strip, which stands up above the surface of the candle, it immediately takes fire. Kingzett's Sulphur Fumigating Candles form a convenient means of producing sulphurous acid gas for the fumigation of infected rooms, the extermination of insect pests, etc. The sample candle has been sent by The Sanitas Company, Limited, Bethnal Green, E.

Pass List.

UNIVERSITY OF LONDON B.S. EXAMINATION, 1893.

EXAMINATION FOR HONOURS.

SECOND CLASS.

Johnson, W. J.

FIRST CONJOINT EXAMINATION, JANUARY, 1894.

ELEMENTARY ANATOMY AND PHYSIOLOGY.

Adams, A. R. — Parsons, J. E. H.
Maturin, A. E. — Treusch, J. B. A.

(PHYSIOLOGY ONLY.)

Blasson, G. H.

Guy's Hospital Bicycle Club.

THE Committee are anxious that this Club shall, in the ensuing year, be supported even more heartily than previously, and feel confident that every cycling member of the Clubs' Union will do his best to further its interests, and make it the most important bicycle club of any hospital. It should be generally known that all misunderstandings and difficulties which caused some dissension at the close of last year have been settled, they feel sure, in a way that will give universal satisfaction.

Cycling members should communicate with the honorary secretary at once, when all necessary information with regard to the arrangements for 1894 shall be forwarded.

Review.

The Amphioxus and its Development. By Dr. B. Hatschek, of Prague; translated and edited by James Tuckey, M.A. London: Swan Sonnenschein.

This work is included in the publishers' "Introductory Science Text-Books," a cheap and efficient series of manuals which we have before had occasion to praise. We are quite sure that any of our readers whose interests lie in the direction of embryology will do well to acquire so excellent a translation of a standard work. We cannot say that the volume is particularly well got up. It is badly bound, while the heavy reading and absence of margin are somewhat annoying to the fastidious reader—at any rate if he be given to making marginal notes during the course of his reading. But this is a small matter, and perhaps after all a question of taste. The illustrations comprise no less than 151 small figures, which would alone make the book worthy of purchase. No subject gains more by plentiful illustration than does embryology, and here we have the development of a most important type reproduced from start to finish as clearly as diagrams can do it. The work is not only descriptive, but for such as are fortunate enough to get material for practical work it forms an excellent laboratory guide.

Rugby Football Prospects.

WITH the break up of the frost, Rugby football again claims attention, and a few remarks at the middle of the season may with advantage be made. Up to Christmas, "on paper" the team has done indifferently—in fact, worse than during the two previous seasons. Ten matches have been played, four won, five lost, and one drawn—the same record, I believe, as St. Thomas's. But when the ill-luck which has deprived the club of the services of two or three of our best men, chiefly behind the scrum, is considered, there really does not seem any reason for discouragement. Then, too, of the matches lost, three would probably have resulted differently had the Hospital been represented by its full strength—reference is made to the Old Merchant Taylors, Coventry and Bristol. At Coventry, five minutes from the start, the team lost the very valuable services of its excellent captain, W. I. Hancock, whose absence alone was sufficient to account for defeat in the two remaining matches. The loss of Bell has been a great blow, and his return to the field to-day will be hailed with great pleasure by all. The absence of any other dependable three-quarters has been the greatest source of weakness, and as misfortunes never come singly, Jones was forced to retire with an injured leg, which has now so far recovered that he will be able to turn out against Croydon. Associated with him, Matthias—a *confrère* of school days—who has lately come down from Christ's College, will, it is hoped, keep the Croydon pair well employed in defence. K. B. Alexander, who has ably earned his cap for Surrey, also turns out to-day. Forward, we have not been so strong for some seasons, and with such men as F. O. Stoker—whose keenness might put some of the older men on their mettle—Slater, Rowlands, "Dubby" Hancock, Shorland and Dudgeon, with the following to choose from for the last three places, Edwards, Pike, Tyson, Bryant and Saward, we ought to do better than Thomas's this year. In Nicholson, who sustained a concussion at Cambridge, the fifteen have lost a hard-working and keen forward, and it is to be hoped he will be able to play again, like his captain, at any rate during the latter part of the season. H. M. Stewart is still available for use as half, or wing three-quarter; while F. C. Wetherell, who has played for the fifteen a plucky and hard game, though, perhaps, hardly fast enough—yet, doubtless, he will develope pace—takes Bertie Hancock's place as centre three-quarter, at Brockley, against the Croydon Club. Meanwhile, it is surely time for fickle "Fortune" to give Guy's a "sunny outing," at any rate so far as preventing accidents to *our* team is concerned.

Calendar of Coming Events.

Jan. 13th.—1st XV. v. Croydon, at Honor Oak Park.
2nd XV. v. Croydon, at Croydon.
1st XI. v. St. Albans, at St. Albans.

" 15th.—Preliminary Scientific and Intermediate, M.B. London Examinations begin.

" 17th.—2nd XV. v. Royal College of Science, at Honor Oak Park.

" 20th.—1st XV. v. Ealing, at Honor Oak Park.
2nd XV. v. St. Thomas's Hospital, at Lambeth.
1st XI. v. Surbiton Hill, at Honor Oak Park.
2nd XI. v. Anerley, at Norwood.
Physical Society Meeting, "Physical Exercise," F. J. Steward.

Marriages.

EMMET—CHASEMORE.—January 1st, at St. Peter's Church, Croydon, by the Rev. C. J. Hollis, M.A., brother-in-law of the bride, John William Emmet, M.R.C.S., L.R.C.P. Lond., to Amy, third daughter of the late Henry Chasemore, J.P., of Croydon.

VICARS—HASKETT-SMITH.—On the 10th instant, at St. Mary's Church, Cadogan Square, S.W., Frederic George Vicars, M.R.C.S., L.R.C.P., son of the late Colonel W. H. Vicars, to Eugénie Matilde, daughter of Captain Haskett-Smith, late Cameronian Highlanders.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

JANUARY 27, 1894.

Inter-Hospital Teams.

THE proposition that Inter-Hospital contests are detrimental to hospital sport, though new to many of our readers, is one that has had numerous supporters at all times, and is just now, perhaps, more stoutly asserted than it has ever been before.

It is with regard to our winter sport that it has so often been said the cup ties ruin football, and now that the premonitory fever of the cup ties is upon us, we propose to lay the question before our readers, hoping that some of them will express their views of the case in our columns, so that when the delirium has passed away, and the cup is safely secured until next year, the powers that be in football matters may consider whether the time is ripe for taking action.

What action? Abolish the cup ties? Perish the thought! If there is no other way than this out of the difficulty, hospital football must be ruined as far as we are concerned. What a day of days is the final cup tie day! What a contest! What enthusiasm! What a crowd! What meetings of old friends! What drawing of the hearts of young and old together in boisterous exultation or silent sympathy! What copy for the GAZETTE'S next issue! But we must curb our enthusiasm, or we shall not be in a fit condition to survey the situation judicially.

As far as we understand it, there are two objections raised against these contests—the first striking at their very existence, the second only at the regulations governing them. Those who uphold the former say that the spirit of contest is too intense to allow good football to be played; but perfect coolness in the midst of wildest excitement and enthusiasm is a trait of character we as Englishmen value highly, and a dropped goal from a loose scrummage is a thing worth living to see. The keener the contest the better we believe it brings out the very best features of really good players, though too much excitement may paralyse those in the second rank. We do not believe this objection to be valid, and even if it were, the loss of *the* day of the year would be too high a price to pay to satisfy the objectors.

The second objection is that the regulation forbidding senior men to play in the cup ties leads the teams of all the hospitals to be decidedly inferior to what they might be did no cup ties exist. Therefore, abolish the cup ties? No; abolish the regulation. Then the best team that each hospital could put in the field would be its cup team, and hospital football would probably be twenty-five per cent. better than it is at present. Every hospital has some champions of the game "out of their year" playing for other London clubs, who would undoubtedly be asked to play for their hospital if they were not by the regulation excluded from the cup ties, and who would have not the least temptation to do otherwise when their presence would make their hospital team equal, if not superior, to the suburban teams for which under present circumstances they play. To turn away our own good men, who would not only benefit us by

their practice but most materially by their precept, is such an obviously false step that one can only conclude that this effect of the regulation was not originally contemplated. Indeed, when cup ties were first started it was not so effective—individualism rather than socialism being the order of the game; constant association in combined play was not so essential to success as it is in the modern game. This change in the character of the game, while it accentuates the ill effects of a year limit for players, has removed the chief argument that has been adduced in its favour. It is said that it prevents ancient heroes of the field being brought up from their practices in the country to play in the cup ties only. Our present committee can tell us what fear there is of such a suicidal policy being adopted.

In the end it comes to this, we are spoiling hospital football all round by enforcing a rule whose sole conceivable advantage might be to produce an artificial equality between the various combatants in the cup ties.

Now, with regard to the well-known incident in 1891, when we had our little difference with St. Thomas's, the fact that the meeting of hospital representatives showed a decided tendency to condone with the offence of a club in playing a fifth year's man, would seem to indicate what the drift of opinion really is in the matter.

St. Thomas's has held the Rugby Cup for five years in succession—whilst in 1891 (owing to the above-mentioned circumstances) the match was not played out—and St. Bartholomew's have kept the Association Cup for four years, with the exception of 1891—when St. Thomas's won. But the question as to who at the present time would gain by the change is immaterial. We should be glad to hear what our three hospital contemporaries and their readers think of the proposal to abolish the year limit in inter-hospital football.

Abstract of Clinical Lecture on Cancer of the Tongue.

BY MR. DURHAM.

Two cases in Lazarus ward at the present time—both of which have been operated on—illustrated very well the nature and course of the disease, and now shew the results of what is probably the best treatment, so far as our present knowledge goes. They will form a text for the following remarks.

Speaking generally, epithelioma is not so rapidly fatal as other forms of cancer, but that of the tongue is an exception in this respect, and is a very fatal form indeed.

Statistics—whatever they may be worth—seem to show that in cases of epithelioma elsewhere, the average duration of life after the first appearance of disease is three and a half years; in the case of the tongue it is little more than one year. This is in untreated cases.

I shall show that efficient removal gives a fair chance of comfort and prolonged life. Operations are apt to fail because undertaken too late, and because the removal of growth is incomplete. That they may be very successful the following case will prove.

On the 17th of December, 1873, a case was admitted into Naaman ward under my care with advanced and unmistakable cancer. The anterior two-thirds of the tongue were removed by the galvanic cautery écraseur. In those days this was considered the best method of removal, and I have seen many good results follow its use, though I am not going to recommend it to-day. The patient did well in this case after the operation, but he returned six months later with the glands affected, and the surrounding structures infiltrated. He had delayed too long, and there was a large, hard, fixed, and painful tumour under the jaw. I operated again, and can tell you that I made a pretty clean sweep of the parts on the floor of the mouth and round

the root of the tongue. Yet, in the twenty years which have followed, the patient has had good general health and comparative comfort. He would have been here to-day, but some time ago he had an operation for cancer of the rectum, so that he finds it difficult to leave home. Let it be remembered, however, that although his was a case of advanced and established epithelioma of the tongue, there has been no local recurrence for twenty years. He is now in his seventy-seventh year, and he illustrates well, I think, the advantages of a full, free, and timely operation.

In another case the patient was alive and well fifteen years after the operation. He may be so still, but at the end of that period I lost sight of him.

It is easy to get a wrong mental impression of the rapidity of recurrence after operations of this kind. Those patients in which the disease recurs quickly come back, while the case is fresh in your mind, and impress you with the sense of failure, but don't forget those who have not so come back.

The following are the cases in Lazarus:—

CASE I.—W. H., æt. 45. Tongue first sore five to six months ago, which patient put down to irritation of teeth. Has never been a great smoker, but uses a clay pipe. There was on admission (as you will see from the specimen on the table) well marked epithelioma. Patient suffered much pain, especially in the course of the inferior dental nerve.

Irritation as a predisposing cause.—I need not say how often broken, sharp and irritating teeth are to blame in these cases. Even the public is becoming impressed with the importance of this fact. A lady came to me the other day with cancer of the breast, and told me, as a contribution to the history, that she had had cancer of the tongue at the age of fifteen. I told her that wouldn't do at all; but she stuck to her point, and said that a dentist had seen to the teeth, and then the cancer disappeared! It is just as well, perhaps, that people should have exaggerated ideas on the subject.

Next to jagged teeth, as a source of irritation, comes smoking a clay pipe. This is, probably, a more common cause of cancer of the lip, but it is certain that smoking should be avoided altogether while any sore exists on the tongue.

Pain.—Often a most prominent symptom, and exceedingly severe. It is felt not only at the seat of the ulcer, but bears out the principle so much insisted upon by Mr. Hilton, and is found anywhere in the distribution of the third division of the fifth nerve.

Movements of the tongue soon become interfered with, the organ is bound down and fixed. Note that syphilitic trouble mostly leaves the tongue free to move.

Position.—The disease mostly begins at one side of the organ, or laterally on the dorsum. It seldom involves the tip at first.

Glands.—The glands are always involved—sooner or later. One may say sooner rather than later. In syphilis they may also be affected, but late rather than soon.

CASE II.—Patient has been a great smoker, and uses a clay pipe. His teeth are very bad. He had syphilis when twenty-eight, and says he has had it three times. At any rate there is a clear history of infection. The tongue trouble began a year ago, when he was treated with mercury till the teeth became loose. The ulceration of the tongue did not clear up however, and on admission was extensive, and clearly epitheliomatous.

It may be admitted that patients who have had syphilis and the tongue affected, are more prone to cancer.

The *diagnosis* of epithelioma is usually easy; where any doubt arises it is generally in these syphilitic cases. We may have, of course, a

secondary ulcer of the tongue, or a gumma, which may break down. The former may indurate, but only late in its history. Epithelioma is an indurating growth, which tends to ulcerate; it is indurated from the first. The syphilitic ulcer indurates only secondarily. Gummata are softer altogether.

The great thing is to be able to diagnose *early*. In the Guy's Hospital Reports for 1889, there is a paper by Mr. Jacobson on the "precancerous stage" of epithelioma of the tongue, which I should advise you all to read. This "precancerous stage" is a term first used by Mr. Hutchinson, and expresses a condition which we should all learn to recognise. We may then, as it were, destroy the nest before the eggs are laid! Any papilloma or sore which occurs on the tongue after the age of fifty should be immediately dealt with.

Treatment.—Unhappily cases nearly always come to us late in the course of the disease; and it may be said at once that there is no treatment except that of prompt and free removal. At one time caustics and escharotics were used; but, believe me, such treatment is cruel and utterly unsatisfactory. If freely used caustics produce a horrible state of things in the mouth, and if less freely they do but irritate the growth. Let me say to you that if you have an enemy and feel that you can smash him out, do so by all means; but, if you cannot smash him, don't irritate him—*smooth* him! So with cancer—cut it out if you can, otherwise smooth it. Don't irritate it.

Operations.—When I first came here the only method used was that of ligature. A ligature was put on behind the growth, and the tongue left to slough off. I need not say that the subsequent course was painful and horrible beyond expression, though one saw some satisfactory results. Then came the use of the écraseur, to which Mr. Hutchinson even advocates a return. It gives the advantage of a bloodless operation, but, on the other hand, the bruising and crushing prevents the operator from seeing where he is, and the chain or wire is very apt to slip forward and encroach dangerously near to the growth. The great point is to perform the operation slowly. Mr. Hutchinson says it should take half-an-hour by the clock. The galvanic cautery écraseur has the disadvantage that the battery is apt to fail and the wire to break; moreover, secondary hæmorrhage is liable to follow the use of either form of écraseur.

Whitehead's operation, in which the tongue is removed by scissors, is, rightly and justly, growing more and more into favour. I used it in both the cases now in Lazarus. Personally, I use curved scissors to cut transversely behind the growth, and find that they greatly simplify what is a somewhat difficult step in the operation.

There are certain preliminary steps before the actual operation, which, though not necessary in all cases, are yet, in my judgment, very generally to be recommended. Their necessity will be determined by the amount of fixity of the tongue, and by the distance to which the growth extends back. They are—

(1) Preliminary laryngotomy. This was performed in both the cases just now dealt with. It not only permits of plugging the throat with a sponge, and so avoiding all the dangers of reflux of blood into the larynx, but it also allows the administration of the anæsthetic to continue without interference with the surgeon's work.

(2) Slitting the cheek back to the anterior border of the masseter. This gives much more room for operating.

(3) The use of a ligature through the tongue, not at the tip only, but passed through the organ right behind the growth. This gives a control over the stump, which is very valuable at the later stages of the operation.

Hospital News.

In the Surgical Wards.

UNDER MR. DAVIES-COLLEY.

CORNELIUS 15.—W. F., æt. 21. Admitted on January 8th, for fracture of lower jaw. He was struck on the chin by a piece of an iron plate, broken off an hydraulic capstan by an explosion of gas, used for keeping the water from freezing. Other slight injuries. The fracture was found to be about the middle line, the left fragment being displaced backwards. There was a lacerated wound under the chin. The wound was dressed with boracic lint. A dental splint was tried, but found unsatisfactory, so Mr. Davies-Colley decided to operate.

16th. An incision was made transversely across the under surface of the chin, taking in the wound, and the skin and soft parts reflected upwards. A hole was drilled through the right fragment, backwards, downwards, and inwards to the back of the left fragment. Another hole was drilled directly backwards through the left fragment, at a slightly higher level. A stout wire was passed through and united behind, at the lower margin of the jaw. It was then found that the right fragment dropped, so the fragments were further united by an iron screw starting from the right fragment above the hole used for the wire. The point of the screw reaching through the left fragment was clipped off, as was the head also. The patient's diet was restricted to cold fluids. The part was frequently dressed with hot boracic.

20th. The swelling due to the operation almost subsided. Patient suffers no pain.

22nd. Patient put on a soft diet. He complains of pain from a loosened molar tooth, but none at the seat of fracture. The position of the parts is excellent. Temperature 98.8.

UNDER MR. LANE.

LYDIA 14.—A. B., æt 43. Admitted January 13th. Patient admitted for fluctuating swelling in left side of abdomen, about three inches above iliac crest. First noticed four years ago. Tumour is freely moveable and is tender, has varied considerably in size from time to time, so has the pain. Patient was ordered brandy as her only chance, commencing with half-a-pint weekly, and rising to half-a-gallon weekly. No albuminuria.

Operation.—15th. Left kidney found quite normal. A sarcoma about five inches by four inches was found attached to sigmoid flexure. It was cut out, and the two ends of gut sewn like a purse string and brought over the two halves of one of Murphy's buttons—now used for the first time in England—and sprung together. The wounded bowel was wrapped with iodoform gauze, the flap sewn up, and a drainage tube inserted. There was much oozing that night. Ordered enemata.

16th. Wound dressed; patient allowed milk.

17th. Gauze wrapping removed.

23rd. Wound was examined to-day. Patient had complained during the week of passing wind, etc., through her bandages, but everything was found perfectly normal. The button has not come away yet. Patient going on very well.

In the Medical Wards.

UNDER DR. PYE-SMITH.

MARY 28.—? Tabes Mesenterica.—C. M., æt. 15. Admitted into Martha on January 8th, for a swelling on left side just above anterior superior spine of ilium, and pains in back. Two uncles died of consumption, and her mother has had rheumatic fever twice. Patient was treated for phthisis in Millar Hospital, Greenwich, in December, 1893.

No illness till six months ago, when weakness and pain in back came on, followed by vomiting after meals. She was ordered cod liver oil by her doctor. In October the above swelling appeared. There has been severe pain in left knee, and the swelling was very tender and hurt on least movement.

She was in Martha for ten days, and temperature varied between 102·8 and 98, being higher in evening. The swelling, which had at first been taken for a lumbar abscess, disappeared entirely under nutritious diet.

17th. Admitted into Mary. Mr. Durham thinking of tabes mesenterica. Anæmic, thin, with narrow chest. The hip, back, lungs and heart give normal signs on examination. The liver dulness extends up to sixth rib, but neither liver nor spleen can be felt. The abdomen is slightly retracted, and is rigid. No tumour can be felt, and percussion is normal. There is still sickness, pain in stomach and diarrhœa frequently. Urine normal. Though no tumour is felt, the diagnosis of tabes mesenterica is accepted.

Mary 33.—M. F., æt. 9. Admitted January 20th, with a vague history of jaundice six weeks ago, and pain in abdomen two weeks ago. Some sickness and diarrhœa. Well nourished, not in pain or distress. Abdomen enormously distended, and uniformly so. Walls are tense, no tumour felt, nor can liver or spleen be felt. A well-marked thrill is obtained; slight tenderness. Whole abdomen is dull, except a small tympanitic area in left half of epigastric region. There are enlarged veins over upper abdomen and lower thorax, in which the blood runs downwards.

Teeth normal. Respiratory system normal, but for dulness behind up to an inch below angles of scapulæ, attributed to the ascites. Circulatory system normal. Urine normal, except for small quantity of bile. No œdema of legs or arms. Eyes normal.

Suggestions were made as to origin of the ascites.

1. Tubercular ascites. Common in children.

2. Pylephebitis. In favour of this are the rather rapid onset, and the high temperature on admission, but this is a rare disease.

3. Perihepatitis, unlikely in a child of this age; jaundice is in its favour.

4. Syphilitic cirrhosis, but there are no signs of congenital syphilis.

PHILIP 24.—Old Cerebral Hæmorrhage.—Y. S., æt. 52. Admitted January 9th. In August, 1891, patient had trembling of left arm, with great loss of power in it. One night he was delirious, and next morning could not move left leg. There was no loss of sensation. A month afterwards he had "rheumatic" pains in left leg, and he was in bed for eleven months, after which he got about on crutches.

Left arm and leg are smaller than right, but only as much as disuse can account for. The left arm movements are good. The left knee is kept flexed and stiff, and left ankle is stiff and extended. Elbow-jerk, obtained on both sides, especially left. Knee-jerk lively on left. Ankle-clonus on both sides, especially left toes. Plantar reflexes on both sides. Patient is slow in answering, otherwise intelligent and normal. There is some loss of sensation in left leg. Respiratory and circulatory systems normal. Urine normal.

15th. Patient had a temperature of 100, and it remained for two or three days. Dr. Pye-Smith said it might be, not febrile, but cerebral, as pulse and respiration did not vary much.

PHILIP 27.—W. S., æt. 45. Admitted January 22nd. History of three attacks of rheumatic fever, the last five years ago, when he went to St. Bartholomew's Hospital. On the morning of admission, on his way to work, patient was suddenly seized with severe pain in region of heart, and running down left arm. There was a feeling of numbness in left arm, and shortness of breath. He was brought up and soon recovered.

There is a systolic murmur at apex, traceable into axilla, where an early diastolic murmur is heard also. From this alone the Medical Registrar diagnosed mitral regurgitation and aortic regurgitation. At the base is heard aortic to and fro bruits.

The impulse is in sixth space, just outside nipple line. Dulness is slightly increased. The pulse is strong, full, compressible and water-hammer. From the pulse, and from the fact that patient is fairly well and able to do his work, hypertrophy rather than dilation of heart is thought to be present.

Now that the pain has gone, patient is to all appearance well. The question of angina has been raised. He is being kept in bed on middle diet, and to take Spt. Ammon. Aromat. ʒss, Spirit Æth. Co. ɱxv., Aq. Chloroform ad. ʒi. t.d.s.

UNDER DR. TAYLOR.

MARY 49.—A. P., æt. 39. Admitted December 22nd, 1893, with paralysis of right arm and leg. Patient has had seven children, two miscarriages. Patient noticed weakness in right arm about 1st January, 1893. Had headaches before this, but no dizziness; no fits, no vomiting. Arm got gradually worse; was completely paralysed last September. Six months ago her right leg also began to get weak, but it has never prevented her from walking. During last three months speech has been slightly affected.

Condition on admission.—Vacant expression, drawling speech, slight sensory aphasia. Lower half of right side of face paralysed. Right arm paralysed, no wasting, well-marked wrist-jerk, slight rigidity, sensation normal. Right leg very weak, ankle-clonus, lively knee-jerk, patellar clonus, no wasting, sensation normal. Ophthalmoscope: Right disc normal, left disc pale. Diet full. Mist. Pot. Iod. ʒi. t.d.s. Patient has gradually improved since admission and under treatment.

STEPHEN 11.—R. C., æt. 46. Admitted January 10th, for "giddiness." Cholera when young. Feeling of giddiness began four years ago, since which it has gradually increased. Has only done five weeks' work in last eighteen months, owing to this. Giddiness comes on when patient stands. Says he feels as if he were drunk. Has fallen several times.

Condition on admission.—Speech thick, has difficulty in pronouncing long complex words, as "Biblical," etc. Tongue is slightly tremulous. Walks with legs wide apart, and slowly. When trying to stand two feet together and eyes closed, he sways to and fro, and then jerking his head backwards, makes as if to fall. Legs and grasp are weak. Reflexes present. Slight ankle clonus. Patient cannot concentrate his attention on an object held in front of him and moved in various directions. No nystagmus. Pupils normal. Patient can hear ordinary conversation perfectly well, but cannot hear a watch tick even if pressed against his ears. Patient had been a "boiler maker." Diet full. Mist. Pot. Iod. ʒt. t.d.s.

It was thought at first that this was a case of G. P. I., but patient walked much better the next day, shewed less giddiness, and improved so rapidly, that he went out on the 19th.

STEPHEN 2.—A. L, æt. 52. Admitted January 4th, for pain in epigastrium and extreme dysphagia.

Patient first noticed difficulty in swallowing twelve months ago. This got gradually worse, and three months ago patient saw a doctor, who told him to go into a hospital. Went to Westminster Hospital a month ago; was under Dr. Allchin. Left there, and was sent up to Guy's. During this last three months has had constant pain in epigastrium. Patient lost sixty pounds in weight during this three months.

Condition on admission.—Patient is very thin and worn out with pain. Can only take liquids, nearly the whole of which is returned. Always hungry and thirsty. Tongue furred. Vomit does not give HCl. test. Constipation present. Abdomen is very thin and retracted. No tumour can be felt. Bougies and tubes up to eighteen inches can be passed with ease. When fed with milk by means of a tube, some seems to be vomited up and some regurgitated. Dr. Taylor diagnosed malignant disease, most likely of lower end of œsophagus, though the pain was against this position of the disease. Patient was fed with nutrient enemata and meat suppositories. Patient was also given milk and beef tea

by the mouth, but a good deal of this is vomited or regurgitated. Patient has gained a few pounds in weight since admission.

Mr. Jackson saw patient on 21st, and thought it was most likely cancer of cardic of stomach, involving the opening of the œsophagus. Did not think it advisable to operate.

Patient is having subcutaneous injections of morphia to relieve his pain.

Whiffs from the Smoking-room.

THE classical man entered the Smoking-room one Saturday night with an obvious contusion on his forehead, and several rents in the knees of his trousers. "Hullo!" said the amiable idiot, "been down the Boro'?" Physical anguish made it impossible for the classic to summon up the appropriate scorching look, so he explained that he had merely been ascending the subway staircase, "hinc illæ lacrymæ," he added, pointing to his damaged trousers. The amiable idiot becoming more sympathetic, guessed that he could bore a better staircase with an ordinary corkscrew, and immediately after went off to get a drink. The reading man in the next arm-chair, who was doing psychology for his M.D., remarked what a beautiful instance of the laws of association the A. I. had just afforded. "Yes," said the classical man abstractedly, resenting the neglect of his Latin joke, "but isn't it abominable what dense ignorance of the classics most of the men up here exhibit. They can't even write a prescription in Latin without cutting off the terminations." "Then do you see any advantage," enquired the reading man, "in writing 'curcurbitulæ cruentæ ad lumbos applicandæ,' when you want to order wet capping to the loins?" "I consider," loftily replied the classic, "that we ought to maintain the traditions of the profession as much as possible, but what I am thinking of more especially is the general ignorance of classical literature that men show. Who is there to carry on the torch of the platonist recently departed from among us? I think one might try to rouse dormant linguistic faculties by fixing up at different places about the Hospital appropriate classical quotations. For instance"—here a twinge of pain caused the classical man to stop and press his hand to his injured frontal eminence, and the other gently suggested it was quite time he applied a cold water bandage to his head. Neglecting the interruption he continued: "For instance, one might inscribe over the Hospital entrance to the college subway:—

Facilis decensus Averno
Sed revocare gradum, superasque evadere ad auras
Hoc opus, hic labour est.

And over the doors of the Anatomy Theatre—

Tua me, janitor, tua tristis imago
Sæpius occurrens hæc limina tendere subegit.

"Ah," said the reading man, regarding him attentively, for his pupils had dilated with enthusiasm, and his tumid frontal eminence gave him a look of preternatural, if ill-balanced, intelligence, "you've a soul above pills and powders; you'll never condescend to the petty details of antiseptic surgery." "Antiseptic surgery," exclaimed the classic, rapturously, "why its mysterious rites remind me of the libations and purifications of some ancient temple. See the high priest and his attendant acolytes garbed in impermeable cassocks, and surplices dripping with the sacred lotion, ministering to the suppliant at Æsculapius' shrine, while another in Sibylline tones cries, 'Procul O, procul este, profani,' to all the unclean who would enter the charmed circle. See Æsculapius' handmaids, dreamy-eyed Anæsthesia who casts her drowsy spell upon the suppliant, Asepsis and her sister Antisepsis, who drive far off each vagrant germ, while Electra stands ready to explore the inmost recesses of his frame, and the haunts of the dread Oxyuris." Here the classic stopped for breath, and the reading man, seizing his opportunity, declared he must be going, and went home to look up the subject of Monomania.

H.

Paper read before the Physical Society on the Value of Symptoms in Intestinal Obstruction.

BY MR. H. A. MOFFAT.

(Concluded.

A distinctly fluctuating vomiting is very characteristic of intussusception.

The subject of Mr. Symond's lecture was a malignant growth of rectum. Abdomen was distended, the left side was much softer than right, and here coils were seen and taken for sigmoid, but the operation shewed them to be small intestine, while the sigmoid lay collapsed behind. He gave several other instances.

Fagge gives a case which disappoints all our expectations: of constipation for one month, stercoraceous vomiting. The abdomen was pointed, projecting forwards, not generally distended; sides of abdomen were not at all filled out; no distension of large intestine to be made out; and hard rounded coils could be plainly felt, with marked peristalsis, yet a cancer of rectum could be felt.

Another: small intestinal movements were visible through the flaccid abdomen, yet there was an incomplete stricture in splenic colon. On the other hand, in a case where a large transverse coil was seen above umbilicus, a volvulus of the descending colon was found.

Treves.—A patient died after laparotomy performed on the twelth day for acute obstruction from strangulation of small intestine by an omental band, which was composed of free end of great omentum; and, by the traction to which it had been subjected, it is evident

that the transverse colon must have been dragged upon. During case, a distended transverse colon became prominent and distinctly visible as to its outlines through abdominal parietes (shewn by post mortem).

In another, there was a transverse coil above umbilicus, and the abdomen was immensely swollen, tense and hard. The coil was sigmoid, this case being a volvulus of the lower sigmoid. The sigmoid or omega loop, if distended, would easily reach across to cæcum or up to umbilicus.

A distended coil of intestine is to be distinguished from the sausage like tumour of a volvulus.

A case of carcinoma recti, under Dr. Pye-Smith in 1892. A woman of 74, old constipation. There had been no motion for eight days; abdomen much distended; globular in form; coils visible in elevations and depressions round umbilicus.

Brinton points to the greater diameter of a visible coil of large intestine, and also to a simpler course.

The coils are more likely to be visible when the obstruction is chronic, and time has been given the intestine to hypertrophy, and dilate under the influence of the greater work it has to do. They are also more likely to be visible in obstruction where large intestine can be distended. The presence of extreme visible peristalsis may be a sign that an obstruction, apparently acute, is really due to some chronic cause.

When the stress of the distension falls mainly on the transverse colon, this often bends down in the middle and forms two enormous vertical coils. The distended small intestines are said to be generally transverse, but in the reports of cases which have described the visible coiling, this does not seem to hold true; but such very few reports describe this that it is difficult to say anything: only about a dozen have I seen described.

Volvulus is the form of acute obstruction in which distension is well marked, and here it is extreme.

Symptoms other than obstruction signs.—The collapse often found is a reflex phenomenon due to the shock of injury to the peritoneum and intestinal walls; and so with a sudden and acute lesion, as in strangulation by band, the collapse is well marked; so too in volvulus of the sigmoid where a large extent of peritoneum is injured, and in acute intussusception. The small intestine may show a more severe degree of collapse in its lesions, all writers seeming to say that the small intestine is more sensitive; and its functions, and vascular and nervous supply all point to this conclusion.

The abdominal expression is of no use: Dr. Barlow, "flushed cheeks, anxious look, with shrunken drawn features, sunken eyes and pinched nose." Though it may help one to spot an abdominal case at first sight, I should not think it ever got further than that.

Amount and Quality of Urine.—Fagge assigns the diminution or total suppression of urine to the result of shock, the kidneys being reflexly paralysed. The conditions required for this are a sudden and severe injury, and as these conditions are usually present in obstruction of the small, not of the large, anuria commonly occurs in the former case, but as a diagnostic sign it is not of much use. Further, in acute obstruction with the more violent vomiting, less urine will be excreted. Hence it is rather a symptom of acuteness. Treves gives the fall of pressure in abdominal aorta due to shock as the main cause.

Dr. Barlow seems to have been the great advocate of the old theory of diminished urine with obstruction high up; and he says it is due to want of enough water to hold in solution the urinary constituents and therefore they are not excreted, since they must be in solution before the kidney can separate, and he thinks they act as diuretics during excretion.

Brinton did not regard the position of the obstruction as affecting the amount of urine; but rather the severity of the vomiting.

Bunge says that a larger quantity of the indoxyl sulphate is found in the urine in intestinal obstruction; and that Taffe's experiments on dogs gave this after ligature of small, but not of large intestine. This is his explanation: albumin is absorbed before reaching the large intestine, its ligature makes no difference; whereas after ligature of small intestine the albumin stagnates and undergoes putrefaction. Bunge says the same results were obtained in clinical testing.

Senator objects to this, and opposes it with the entire upsetting of all the digestive and absorptive processes of bowel in acute intestinal obstruction; and he also shows that in wasting diseases indoxyl sulphate is generally increased.

The state of the abdominal walls depends chiefly on the presence or not of peritonitis. Volvulus, almost always producing local peritonitis, causes rigidness very early; and, with other forms, peritonitis only comes on after some time, unless something happens out of the usual run to bring it on sooner.

Discharge of blood or mucus from the anus is important. In acute intussusception it is almost the general thing, *i.e.* in 80 per cent. of cases; in chronic, 50 per cent., not so often; and in cancerous strictures of large intestine blood with mucus is fairly common, less common from small intestine.

Straining at stool is another symptom arising apart from obstruction by the irritation of the mucous membrane, being really an exaggerated reflex. In accordance with the general observation that the body can stand almost any chronic change, the intestine does not show this symptom in chronic intussusceptions so much as in acute. And the nearer the intussusception gets to the anus the greater will be the straining for stool.

It also occurs in volvulus, being often very severe and without intermission.

In stricture of the large intestine it often occurs, and is more prominent the closer to the anus. In fæcal accumulations it is common.

Tumours.—Intussusception, sausage-like, changing in position. Position of tumour and very existence vary in different forms of intussusception. The size, site and fixation also vary, the tumour advancing and retiring. Its different characters during peristalis are important.

In about 50 per cent. of cases of intussusception there is a tumour felt in abdomen, especially in the colic and ileo-colic forms. A tumour felt in rectum or projecting from anus is very frequent.

In a large number of cases of malignant growth it may be felt through abdominal walls, and there are the great class of growth in rectum.

In fæcal impaction the tumour is characteristic; in gall-stone impaction no definite tumours. The cæcum is the usual site of fæcal tumour.

Previous history is hardly a symptom, but still the importance of any former hernia, tending to the formation of a band; injury or peritonitis also pointing to a band; or severe symptoms such as would be caused by the ulceration of a gall-stone into intestine may be noted. Intussusception in children often follows diarrhœa. Volvulus of the sigmoid is almost always after a history of chronic constipation.

So, by a careful consideration of the various symptoms, the time and mode of onset of each, the character and severity of each, and all the symptoms regarded in relation to each other, a diagnosis of the manner and position of obstruction may be at times arrived at. A band is often diagnosed, and a band is found at the post-mortem, or more rarely at the operation. Perhaps, out of every ten cases there will be one decided anomaly where all the usual course is upset by some circumstance; *e.g.*, a growth occasionally causes an acute obstruction.

Advances in Bacteriology.

WE have lately been glancing through the pages of an almost obsolete book recently presented to the Hospital library—the *Micrographic Dictionary*, published nearly twenty years ago. It was a notable book in its day, bearing on its title-page, as the names of its compilers, the names of Dr. Griffiths, the Rev. M. J. Berkeley, Professor Martin Duncan, F.R.S., and Professor Rupert Jones, F.R.S. It forms a complete epitome of the microscopical knowledge of that day, and is illustrated, not only with beautiful wood-cuts interspersed among the text, but with forty-eight very fine copper-plate engravings, embracing thousands of representative delineations of microscopic objects.

But how completely has microscopy (or micrography) been revolutionised during the intervening twenty years. The article "Bacterium" occupies about one 2,000th part of the whole volume, and we transcribe the whole of the article, as representing the bacteriological knowledge in brief of 1874.

"BACTERIUM.—A supposed genus of Oscillatoriæ (Confervoid Algæ), consisting of extremely minute inflexible filaments, more or less distinctly jointed, from imperfect transverse division, often exhibiting a vacillating (not undulatory) movement. Ehrenberg and Dujardin place them among the infusorial animalcules (*Vibrionia*, Ehr. and Duj.); while Cohn regards *B. termo* as an active swarming brood produced by a Palmellaceous Alga (Zoogloœa). The nature of these objects is very obscure.

"1. *B termo*, Duj., *vibrio lineola*, Ehr. in part. Colourless, twice to five times as long as broad, slightly swollen in the middle, composed of one or two joints; length 1–9,000 to 1–12,000″; breadth 1–12,000 to 1–50,000″. Placed by Ehrenberg with his *vibrio lineola*, Ehr.

"One of the earliest organisms appearing in decaying and putrefying animal and vegetable solutions; by some, supposed to cause the decomposition, and to form the microzymes of zymotic diseases.

"2. *B. catenula*, Duj. Filiform, colourless, frequently three to five joints; total length 1–1,250″; joints 1–7,000 to 1–6,000″ long, 1–60,000″ broad.

"Probably only a degree of development of *vibrio bacillus*.

"3. *B. punctum*, Ehr. Ovoid-elongate, colourless, movement slow, vacillating, often in twos; length 1–5,000″; breadth 1–10,000″.

"4. *B. triloculare*, Ehr. Oval, two to five times as long as broad, with from three to six joints; length 1–2,000 to 1–5,000″; breadth 1–10,000″.

"BIBL.—Ehrenberg, *Infus.*; Dujardin, *Infus.*; Cohn, *Nova Act.* de 1854, xxiv., 101; *Qu. Mic. Journ.*, iii., p. 206; Sanderson, *Privy Council Med. Rep.*, 1870, p. 243; Lüders and Hensen, *Qu. Mic. Journ.*, 1868, p. 32; Hoffmann, *Ann. d. Sc. Mat.* (*Bot.*), 1869, p. 5."

If the reader will turn to one of the numerous manuals of bacteriology of the present day, he will see that enormous strides have been made in this science during the last twenty years. At the present time bacteriology lies, or is supposed to lie, at the root of all medical science.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I wish to point out an inaccuracy in the report of a case under Mr. Lane (Lydia 10), which appeared in your issue of December 16th, 1893. The statement to which I refer is as follows:—"On May 21st, 1893, she went to Wisbech Hospital where she remained for seventeen weeks, but nothing was done, they wishing to amputate but she refusing."

During the time A. M. was in Wisbech Hospital, she was treated (1) with iodides internally and the swelling was painted with Lin. Iodid.; (2) with rest, back splint, and pressure; (3) with Scott's dressing and strapping. The swelling was also punctured with an exploring needle.

After watching the case carefully, and observing the effect of the remedies applied, a diagnosis of sarcoma was made. The diagnosis was much assisted by observing a well-marked pulsation in the tumour, synchronous with

the beats of the heart, and I do not see any mention of this symptom in your report of the case.

After making this diagnosis amputation was advised and refused; the patient went out on the understanding that if further treatment was sought she would again come to Wisbech Hospital.

In justice to our hospital, which, by-the-bye, is The North Cambridgeshire Cottage Hospital, I shall be much obliged if you will kindly insert this letter.—Yours truly,

ARTHUR W. CLARK.

6, The Crescent, Wisbech,
8th January, 1894.

SIR,—The late notes in the GAZETTE on "Antiseptic Precautions, etc.," recall to my mind the remarks that I made on the subject when, five years ago, I was delivering the Presidential address of the Bath and Bristol Branch of the British Medical Association. It seems to me that my prophecy is coming true sooner than I anticipated.

"Listerism," if it have no other advantages, has at least this merit, that it has induced surgeons to regard cleanliness in person, instruments, and all the paraphernalia of an operation as of paramount importance. It is not an easy matter to clean one's hands before or after an operation, and a careless washer, even with the aid of a nail brush, may utterly fail to make his hands aseptic. Indeed, if we may judge from some experiments made by the German surgeons, a few minutes' vigorous washing coupled with five per cent. carbolic acid, failed to make fourteen out of fifteen persons' hands free from infecting sterilized gelatine. Still, I feel that to these increased efforts after cleanliness in all appertaining to an operation—call it Listerism, or what you please—we owe much, very much. Would that carbolic acid could prevent our bodies from being, under certain conditions, manufactories of germ-life. Sometimes, as I have meditated over this, I have hesitated to pronounce this germ discovery as an unmixed blessing, doubting whether we have not rather breathed life into a Frankenstein, which will prove beyond our powers of control. The cry is, still they come. Microscopists seem to discover fresh cocci and bacilli in every direction. Is diagnosis going to be reduced to microscopic research, and the discovery of some organism for every disease? By the time that a few more are discovered, the public will believe that every disease is germ-producing, and that we, the profession, are the licensed germ carriers, and with the possibility that at any step we may encounter a micrococcus or streptococcus beyond our ken, *medical life will scarcely be worth living.* Meanwhile, the opinion that many of these tiny organisms are common to other animals as well as man, will tend to embitter the lives of those who are devoted to domestic pets.

And here, as bearing on this subject, let me add this rather amusing sketch from the columns of the *St. James's Gazette.*

THE LOVER OF THE BACILLI.

A PHYSIOLOGICAL IDYLL.

(The comma Bacillus is, according to Koch, the germ of cholera.)

Quoth Bacillus to Bacilla
(Surely everything has sex):
It is quite enough to fill a
Soul with pride, to see the necks
Of these mighty men of science,
O'er the microscope bent low,
While beneath them in defiance,
Spins the merry Vibrio.

Proud am I to think my comma,
While the world rolls on its way,
Every fell disease springs from a
Fairy filament, they say.
Autocrats, that tower Titanic,
Have been known to bow to me,
Mighty potentates in panic,
Disinfect at thought of thee!

Rash would he be, who should presage,
That no germs behind us are;
We are part of that great message,
That outrings 'twixt earth and star.
What by thousands, or by tens is
Multiplied, in vain they show
Something lies beyond his lenses,
Mortal man may never know!

We are greater my Bacilla,
Than all monarchs, for it seems
We need but exist to fill a
Strong man's brain with fever dreams,
Such the thought my passion kindles,
O my microscopic bride,
Kiss me! although twenty Tyndall's
Have their eyes upon the slide.

H. S. C.

It is to my mind, an additional weighty anxiety to every conscientious man, and the profession has already its fair share of responsibilities to bear.—I have the honor to be, yours faithfully,

JOSEPH HINTON.

The Cottage, Batheaston.

Acknowledgments.

Common Neurosis. Goodhart, M.D. Second Edition. (London: H. K. Lewis.) 3/6.
Report for 1893 of the Liverpool Medical Institution.
The Hospital.
The Medical Press.
The St. George's Hospital Gazette.
The St. Thomas's Hospital Gazette.

Passim.

IF our readers would only help us, Passim might be made much more to the point than it usually is. Sir Boyle Roche's famous bird had a monopoly of the power of being in several places at once, and at present we have no reporter who can undertake to keep us posted on current events all over the Hospital. Why should not everybody let us have a paragraph when they light upon the occasion for one? Such might be left at the Medical Office or in the Editors' box at any time. All who wish us well please note.

THE leading article in to-day's issue is not strictly editorial. It is an expression of opinion from a source entitled to the greatest respect, and the matter is of vital importance to hospital sport. We, therefore, give it the most prominent position possible, with the wish that it may bring about adequate discussion of the matter in our columns. We hope to receive the views of many of our readers. Those who have thought about the matter will do well to write at once, for if any change is to take place in the constitution of inter-hospital teams the time is almost ripe for action.

EVERYONE will rejoice to learn that Mr. Durham has accepted the invitation sent him by certain of his old House-Surgeons and Dressers to meet at dinner—not only the old firm, but all other Guy's men who may be able to be present. The date fixed is March 31st, and the place the St. James's Restaurant. The tickets—which, we may mention, can be obtained of Messrs. R. H. Fagge and T. M. Nicholson—are 10s. 6d. each. It is more than likely to be a really historic occasion.

THE Debating Society proposes to hold a meeting on February 10th, which it is hoped will take the form of a ladies' night. The subject is not announced at the time of going to press, but those who are interested will find notices in the Colonnade and elsewhere within the next few days.

WE are uncommonly delighted to hear that the Life Members of the Clubs' Union are shewing great unanimity in continuing their support to the Reports and to the GAZETTE. At the outset, pessimistic prophets looked upon the necessary exception of these two constituents of the Union from life compositions as a weak part of the scheme; but experience shews that they were wrong.

WE are glad to note that the experts are once again operating on the electric indicator in the smoking-room. It is to be hoped that the apparatus will make a good recovery, and, for the future, have some little regard for veracity.

THE recent appointment of five additional anæsthetists necessitated some alteration in the appointment of their clerks, so a word of explanation as to the system adopted with regard to the time and mode of applying for these appointments may be useful. The appointment is now to be held for one month, and applications are to be made on the usual forms at the Medical Office, not later than the middle of the preceding month. Each applicant should state on the form to whom he wishes to be attached, as the clerks are specially appointed to one or other of the anæsthetists. He should also state the day on which he wishes to attend.

Dr. Silk	attends on	Tuesdays,	in Operation Theatre.
Mr. Rowell	„	Fridays,	„ „ „
„	„	Tuesdays,	„ Out-Patient Dept.
Mr. Ogle	„	Fridays,	„ „ „
Dr. Lancaster	„	Mondays,	„ Eye Wards.
Dr. Hamilton	„	Thursdays	„ „

Pass List, January, 1894.

SECOND CONJOINT EXAMINATION.

ANATOMY AND PHYSIOLOGY.

Clarke, W. T.	Hancock, E. D.
Evans, C. R.	Lower, N. Y.
Garland, J. O.	Rice, D.
Glover, J. A.	Rowland, R. J.

ANATOMY ONLY.

Golding-Bird, F.	Pearson, G. B.
Kay, R.	Reckitt, W. F.

PHYSIOLOGY ONLY

Curtis, P. J.	Hort, E. C.
Desprez, H. S.	Instone, B.
Dudgeon H. W.	Rowland, L. T. A.
Finch, A. H.	Sunavala, R. B.
Goodridge, W. L. T.	Waymark, W. E.
Higgins, C. P.	Wernet, A. J.

FIRST CONJOINT EXAMINATION.

ELEMENTARY ANATOMY
(Under Regulations dated January 1st, 1892).
McIlroy, W.

ELEMENTARY BIOLOGY.

Cawston, E. A. S.	Pawle, M. G.
Green, W. R.	Shepherd, C.
Harrison, S.	Watt, J. G.

CHEMISTRY AND PHYSICS
(Under Regulations dated January 1st, 1892).

Green, W. R.	Kinsey-Morgan, A.
Harvey, W. J. S.	Longhurst, E. A.
Heath, F. H. R.	Lower, C. A.

Shepherd, C.

CHEMISTRY AND CHEMICAL PHYSICS.

Brookhouse, C. S.	Isaac, B.
Cogan, L. D. B.	Mann, C. J. H.

MATERIA MEDICA AND PHARMACY.

Booker, C. W.	Hills, W. E.
Fryer, E.	Temple, P. G.

Wernet, A. J.

PRACTICAL PHARMACY.
Milton, W. T.

Bicycle Club.

The club is to hold a supper on the 30th inst., at "The Moorgate," Finsbury Pavement, at seven o'clock precisely. Tickets, 3s. 6d. each, may be obtained of the secretary. Mr. Golding-Bird is to preside. Members are fortunate in having so kindly a president, always ready to assist them in anything they do. Mr. Golding-Bird was able to help them the other day in a matter of some little difficulty. He presided at a meeting where the question of the resignation of the captain came up. This was tendered, but not accepted. We are sure that the affairs of the club will now progress smoothly and satisfactorily as heretofore.

Calendar of Coming Events.

Jan. 27th.—1st XV. v. Rosslyn Park, at Acton.
2nd XV. v. Rosslyn Park, at Honor Oak Park.
1st XI. v. Surbiton Hill, at Honor Oak Park (Second Round Surrey Cup).
Smoking Concert at 7.30.
" 31st.—1st XV. v. R. I. E. C., at Coopers' Hill.
Feb. 3rd.—1st XV. v. Clapham Rovers, at Wandsworth.
2nd XV. v. Barnes, at Barnes.
1st XI. v. Chiswick Park, at Honor Oak Park.
Meeting of Physical Society—"The Decadence of Teeth," H. Stoner.
" 7th.—2nd XI. v. St. Bart.'s Hospital, at Honor Oak Park.

From the Gazette's Special Pathologist.

W., SALISBURY.—The mass removed by curette is a rapidly-growing glandular carcinoma, probably starting in the fundus. The superficial part shews modified glandular cells; while the deeper is composed of solid columns of epithelial cells.

W. H. M., KIDDERMINSTER.—January 9th. Chronic mastitis.

January 15th (No. 1). Carcinoma mammæ; stroma approaches scirrhus type and shews mucoid change of connective tissue.

(No. 2).—The specimen from the brain is a carcinoma, probably a secondary deposit. No primary source was found in organs sent, but there were signs of obstructive jaundice in the liver, and the gall bladder shewed the effects of chronic inflammation. Probably, therefore, the primary growth was in this neighbourhood, possibly in ducts.

Details:—Brain specimen.—Vascular growth mostly composed of epithelial cells; arranged, some in aggregations suggestive of second epithelioma, others in columns and infiltrations.

Gall bladder.—Wall thickened; chronic catarrh of mucous membrane.

Liver.—Inflammatory change around bile ducts; fatty change and deposit of pigment in hepatic vein and pancreas. Post-mortem change too advanced for microscopical examination.

Many thanks for specimens.

C. D. M., BOURNEMOUTH.—No tubercle bacilli observed.

H. V. H., WANSTEAD.—No tubercle bacilli observed.

PATHOLOGIST.

Specimens for examination and description in this column, should be addressed to H. HUNT, GAZETTE, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

How should we study Medicine?

THE LECTURE INTRODUCTORY TO SESSION 1868-9, AT GUY'S HOSPITAL.

BY WALTER MOXON, M.D.,

FELLOW OF THE ROYAL COLLEGE OF PHYSICIANS.

(Continued.)

Let us quickly glance at some sciences to compare their main features, and keep in view at the same time the great practical aim with which we all enter here: the knowledge of what are called the "sciences" of Medicine and Surgery.

Sciences come under three great divisions. Let us look at a type of each.

Firstly, Mathematics is a type of a pure science; it is pure reasoning. You go from step to step without any conscious reference to anything outside you.

Secondly, Chemistry is a type of sciences reasoning from the facts of nature. You cannot go a step without direct reference to the substances of your chemistry. You must use observation as well as reasoning. But so well are the chemical elements known, and their laws of combination ascertained, that a young chemist's reasoning goes hand in hand with his observation.

Thirdly, Zoology is a type of an entirely different sort of science; for just as mathematics excludes observation, and is pure reasoning, so zoology excludes reasoning, and is pure observation. You do nothing but observe, and compare, and classify the objects of your zoology.

Now, every true science is like one of these three types. Let us inquire to which of them the so-called Science of Medicine belongs. (I use the term "science of medicine," and I intend it to include two things; first, the knowledge of diseases, scientifically, if possible, and, secondly, the knowledge of remedies, scientifically if possible. The art of medicine is the application of the second knowledge to the first.)

Now, let us lead up the knowledge we have of diseases, and see whether it corresponds to any of these three types of science.

First, Is it like mathematics? Well, plainly, no. With mathematics and its like, as a study, we have nothing further to do; they did their work in us, for better or for worse, when we learnt them at school. They did this for us, they practised us in concentrating our whole thought on each particular step in a train of reasoning, to make it sure that we might leave it, and go on and concentrate on the next step in confidence that all before was sound. We now must leave their application to the actuary, and land surveyor, and mariner.

Secondly, Is the science of diseases like the science of chemistry? Well, no. It is true that as drug-prescribers, and so forth, we must deal directly with chemical knowledge, and must know it practically and well. But that is quite another thing. There is no science of diseases like the science of Chemistry. The characteristic of chemistry is, that it is constructive from the elements of nature, as mathematics is constructive from the elements of thought. But we have no constructive knowledge of diseases. We do not know how they are put together, how they are caused.

Well, then, for the third time, Is there a science of diseases comparable to the science of Zoology? Can we lay out before us the facts of disease as in a museum, and arrange them in natural orders, and genera, and species as a zoologist does his animals? Why, we can try, and we do try; but our first attempt is crossed by this strange difficulty, that we cannot quite know what the things are that our science is to be about. A science of diseases. But what is a disease? Very able and learned physicians, great pathologists, and men we are proud of, have recently been writing on the question, what is a disease? The question is very simple. A baby might ask it. But the answer is so cloudy, the doctors don't seem to understand it. But, you say, surely we have a knowledge of what we mean when we speak of a disease. Well, let us take a "common sense" view of that knowledge.

Practically, to us, a disease is—what we know of a patient's malady. But see, we know in three degrees of penetration, as it were. This is what actually exists in any patient, a cause of a physical change that induces suffering.

Now, if we knew cause, and physical change, and suffering, if we could apprehend the whole disease, then we could compare one with another, and make a sort of zoology of them. But most unhappily this is the rule:

The suffering the patient knows;
The physical change the doctor knows; and
The cause God alone knows.

Well, but even then you say, if the doctor knows always the physical changes in his patients, if he can go up to and make out the changes of tissue in the living person, then he could classify those tissue changes, and make a sort of quasi-zoological morbid anatomy of his living patients. But unhappily too often he only knows as far as the patient (without the patient's certainty), and cannot get beyond the patient's story of suffering; and equally unfortunately for the classifying purpose, he sometimes knows the cause, which is usually hidden.

And hence arises a confusion which has never yet been extricated. He cannot classify diseases, because what he knows of them is not comparable knowledge. For while one disease is a pain in the leg, and another a growth in the stomach, and another a spider in the skin, the classification of them is worse than mixing incompatibles, it is mixing things indifferent. It is like trying to mix the solar spectrum and the key of C major with essence of peppermint. Many diseases are not certainly real, and many are not distinct from each other.

And no zoology could exist where species are not distinct. There is no zoology of mongrel dogs; and no zoology can exist where the creatures of it cannot be

directly observed. There could be no zoology if a bugbear and a griffin might for all we knew be as real as a lion or a tiger.

But, you say, what business have I to rise up and say that such and such are the types of science, and what is not like one of these three types is no science. And you say, "Have we not many sciences besides these?" Is there not the science of anatomy, and the science of physiology, and of materia medica. Well, let me speak plainly. Anatomy is not a science. It is no more a science than a coachman's knowledge of the way about town is a science; and believe me it is only to be got as a coachman gets his knowledge of the way about town—that is, by going over the ground yourself, with all your wits about you.

And then, physiology. No more is that a science. Pray give me your attention for a minute or two, while I lay before you its relations to science, because it is through physiology that medicine comes nearest to the sciences.

What is physiology? Look at it.—It consists of a knowledge of the different systems of the body—of the muscles, myology; of the nerves, neurology; of the glands, etc. Now look at any of these:—

Myology is—1. An account of the structure of muscle.
2. An account of the growth of muscle.
3. Certain problems in mechanics.

Neurology is—1. An account of the structure of nerves.
2. An account of the growth of nerves.
3. Certain problems in electricity.

And so the physiology of the gland systems consist of the history of the structure and growth of glands and certain problems in chemistry.

But physiology must not claim to be a science, because it borrows of chemistry and mechanics. It must render unto chemistry that which is of chemistry, and then be judged by what remains intrinsic and proper to itself. Now the scientific part of physiology is made up entirely of those chemical, mechanical and electrical problems that are wrought out in the body. And the accounts of structure and development, which alone are proper to physiology, are so much mere narrative of matters of fact, which we tell over like a tale—a really wonderful, and often a beautiful, and always a highly interesting story, but still only a narrative. We have no reasons for the changes, and no general characters for the appearances; and so it itself is not a science, it only needs that you be learned to a certain extent in other sciences to follow its stories.

But, you will say, "What is it to you whether you are to call it a science or no, so you have to learn it." Why, it is precisely because you have to learn it that it makes every difference to you; and this is why: because common knowledge of facts, such as physiology is, cannot be learnt as science is learnt. A man may be a very good mathematician, or a very good chemist, or have a very good knowledge of the classification that composes zoology, who had shut himself up in his study to learn. Because science treats of mere relations, and relations are naturally expressed in words, and are fully and completely expressed in words: words will utter all the whole that science consists of. But no amount of words can teach the matters of fact of common knowledge, which I have shown you that what is proper to physiology consists of. You can only learn these facts by seeing and hearing for yourselves. That is the practical issue I want to lead you to, you cannot overestimate its importance. But you cannot always see the facts of physiology for yourselves, they require skill and time for their development; and hence I am glad to tell you, that in the Physiological Lectures at Guy's, you will have those facts brought practically before you, which you cannot show yourselves. So I recommend you to go always to physiology lecture, whether you can get to anatomy or no.

Now I have shown you that the knowledge of disease is not a science, there is no science of Medicine; and also that the branches of knowledge that more properly and immediately belong to doctors—Anatomy and Physiology, and, much more, Materia Medica—are not sciences; but as it were bring us down into connection with sciences that enter partially into them, and so serve to link medicine with the sciences.

I hope you will now fully recognise that there is no science of disease, as it is met at the bedside. The so-called Nosology is a mere string of names, for the convenient registration of the deaths in the population, and for similar purposes.

Now, then, comes a cardinal view, which I want you firmly to apprehend; it is this:—You must not study disease as a science is studied; you cannot get the knowledge of disease as you get the knowledge of sciences—in the study—as you get your mathematics, and chemistry, and zoology. You must know diseases, not as the zoologist knows his species, and his genera, and his orders, by descriptions of comparative character, but as the hunter knows his tigers, and panthers, and wild boars. You must know as he knows—by seeing them, and facing them in their natural states and places. Study individual cases in the wards. The use of individual cases in the study of medicine and surgery, is like the reading of biographies in the study of history. You cannot know history except by biography, your schoolboy-smattering then becomes familiarity. No other person can give you this familiarity with diseases—familiarity is the word, not mere knowledge. They cannot give it you either by book or speech. The most graphic description of disease is at best like a landscape taken from a railway-carriage at full speed. Or like one of those pictures of glorious battles you see in the printshops, where the live and violent struggle is chilled into a set of shapes, with every man's hand lifted against his neighbour, without ever coming down. You must see for yourselves; and see assiduously and well. I pity the lecturer on medicine, he is under the greatest of all burdens—the burden of the incommunicable—and you

are happy when he is one of those great men who can nearly say what cannot be said.

How then, you ask, are we to be, in the vulgar sense of the term, "Practical Men," and discard science? Gentlemen, all I have said demands imperatively the very reverse. Such practical men have woke up in the wrong century, they should have lived before.

For see, if there is no science for the practice of medicine, so much the more must we bring the science in our minds, that the order within may overcome the disorder without. For, gentlemen, the human mind is like that centurion in Scripture, who was set under authority and yet had others under him. Our minds fall under what is methodized, that they may themselves be organized; and they rise over what is unmethodized to organize it. And if, in our daily duty, we are to use our reason freely amidst what is not wholly obedient to reason's law, we must discipline our reason. Here, above everywhere, to be able to command we must have learned to obey. For just as the colonel of irregulars must be a very genius of discipline, so the physician must be the most disciplined of minds, for he, too, has to use disorderly elements according to method.

This, gentlemen, is the true theory of medical education; we want minds that are at once free and devoted to scientific order. This is the theory, and those who have to regulate, and those, much more, who have to pass through it, should fully apprehend its difficulty. You must see plainly, that two opposite things are required of you, lest your house be divided against itself. First, you must be orderly minded scientific men; and second, you must be free to judge what is not capable of scientific certainty. You must not in freedom lose your discipline, nor in discipline surrender your freedom. If you do either, you will turn out to be but an abortion of a doctor, fit only for rough duty in some corner.

Now for a cardinal proposition. It is this: The two opposite demands on you for discipline and freedom must be supplied from opposite sources. Discipline will be forced on you by the medical council; freedom you can only get by self-culture. No one can give you this freedom from without, if your freedom does not arise within. In vain the most "liberal" of parties thrusts freedom on you. Those outside yourself can only push you off one master to fall to another, and make you a shifty slave instead of a constant slave. However various the master, to a born slave all is slavery. But, *Servitutem qui contempsit, in quantalibet turba dominantium liber est.* I say you will be disciplined by the medical council; they won't care for your freedom, they will cut your garment of learning to their regulation model of a doctor, whatever your figure may happen to be.

Some members of the medical council appear too much to forget the essentially free and responsible judgment which is required of every medical man, in the case of every life under his care; and they want to prescribe rigid rules for every hour of every day of your student life; and would grow you to the shape they like, as a gardener grows a plum-tree. As though they were vain enough to think that what they can give you is enough to fit you to cope with the amazing difficulties of your calling! What substitute can they give you for self-help, for which they would allow you no time? Let them see that nothing in their *curriculum* can take the place of self-respect, of self-command, of self-development. They are forcing men to learn, as if it is only our seniors that can infuse learning into us. But if we are not to lovingly cultivate it in ourselves as a generous natural growth, then there is no future for human knowledge. They must trust the rising generation, and hope that wisdom will not die with them. Their proper and efficient guarantee is in the examination. What we want are examiners who know ignorance and foolishness when they meet it, and have resolution and public spirit to promptly and sternly prevent it entering the profession. If we have such examiners, why need we trammel every hour of a student's day; if we have not, then let the medical council turn their energies to educating examiners, and supply them to us.

I say, that in point of discipline, you will find excess rather than deficiency. You will be very carefully trained, you will not be formed in one operation either, but come out in stages in a sort of geological method. If you are elaborated by the London University, you will have to show a sort of unstratified primary basis of classics and other schoolboy learning before she will take you in hand. Then, at preliminary scientific, you will complete a sort of stratified primary of chemistry, botany and zoology. Then at first M.B., show that you have received a secondary series of anatomy, materia medica, etc. Then at second M.B., exhibit a sort of lower tertiary eocene of medicine and surgery as yet undifferentiated; and finally, at upper tertiary M.D., you produce your beautiful fertile and various completed sphere, and you may bring your delighted friends to sing for joy over it.

This is all like enough to Nature. Oken says, "Man is a planet upon the planet," and it seems right enough, if so, that he should come out in a properly geological method; but mind you gravitate to your own centre. Yet it certainly seems a pity that the learning should not all exist together, but that one layer must cover another, like so many coats of paint. As it is, I fear that any complete medical sphere among us must allow that he only can show bits of these several earlier formations where they are denuded by accident, or upheaved by some casual quasi-convulsive scientific effort. Such a system only shows that a man has, at different times, known a great deal—not that he ever did know a great deal, much less that he knows it now. We see, and are surprised at, the great bushel of learning that has been ladled up; but it was done at so many lifts, that the measure may be only a half-pint after all.

(To be continued.)

A Journey to the Tomb of Harvey.

HAVE you ever, reader, been bored to death with Guy's? Perhaps you have not the honesty to confess this weakness; but personally I, being one past all shame, readily acknowledge periodic attacks of weariness at all pertaining to medicine and surgery. At times, for me, the bewitching fascination of the out-patient department itself loses all charm, and I am even compelled to absent myself in search of bucolic delights.

But for this weakness I should never have undertaken my interesting pilgrimage to the tomb of Harvey, nor should I be delighting numerous gentle readers with these circumstances.

On a pilgrimage of any kind I knew I could count on the companionship of my friend, Frederick Allright, Esquire, as a man of polite manners, and possessed of a profound knowledge of the science of chemistry.

I therefore sought out this excellent man, whom I found busy catching butterflies, a pastime in which he finds considerable diversion.

He stared blankly when I mentioned the name of Harvey, and confessed ignorance of that illustrious personage. At this I was not surprised, as Allright is a thorough Guy's man—esprit de corps to the finger tips—one who stolidly ignores those poor wretches who have not had our educational training, or who have turned deaf ears to the advantages set forth in our Green Book. Though denying Harvey the credit of discovering the circulation of the blood, Allright added, "I will not confute you that your Folkestone worthy did discover that appetising sauce which bears his name." Argument with such a man being useless, I contented myself with his promise to accompany me, and shortly afterwards we both set out on our journey.

Essex is little travelled by the tourist except round its sea margin (where it is indeed visited); therefore, were the country flatter than Holland, it would commend itself to those, who, like some of us at times, prefer "cocks, hens, haystacks, and those sort of things" to one's fellow creatures. The whole country is full of interest and delightfully picturesque, which is quite compatible with absolute flatness, although fortunately, the average Briton thinks otherwise, which is in itself an advantage, as one knows where to go to avoid him. But patriotism seals my lips and reminds me that I originally intended to describe our pilgrimage end.

Harvey lies buried at Hempstead, a charming little village, exactly seven miles east of Saffron Walden, the latter town being approached by a well-kept level road from London, by Bishop's Stortford.

Most of the village churches in Essex hitherto visited by us had been spared by some chance from the ruthless hand of the restorer, and from the curse of those mercenary churchmen who find that old oak pews have a market value, and who have a predilection for those of varnished deal; we were disappointed, therefore, to behold a trim building, unworthy of the name of a church, glaring at us in horrible newness.

An old lady, with silvery hair, came out of the cottage near by, and chinking the keys, asked whether we had come to see "the Doctor." She informed us as we walked up the hill to the church, that she had lived all her life in the Harvey family (evidently as an Abigail), that she now kept the church and looked after the old Doctor and the rest of them, *i.e.*, those in the great vault. We further learned that our guide had, up to January 28th, 1882, been in the habit of mounting the church tower to wind the clock; on that day the curate, a very nice-spoken gentleman, mildly cautioned her not to climb the shaky tower. The structure was considered unsafe, and workpeople had actually been engaged to commence its repair. But alas! too late! that very night down crashed the whole tower, wrecking the building, the old bells clanging fiercely as they were torn from their resting place and hurled on the green.

"But that was not the worst that happened," said the old lady, "we now had the College of Physicians down on us! They tried all they could to get hold of the poor old Doctor himself, to take him to Westminster Abbey, they told us; and they would have had him sure enough had not our young ladies stood firm and forbid it. A nice lot they are indeed, with their body-snatching ways! But just look what they did do," said she, unlocking the church, "they actually pulled the dear old Doctor up from the vault where he had lain since 1657, and put him in *that thing!*"

The thing indicated was described in the guide-book as "a handsome sarcophagus, formed of a single block of Carrara marble." In our opinion it was more admirable for its pounds—avoirdupois—than for its beauty.

The whole church was new and the Harvey Chapel was entirely re-built. Fortunately, in the devastation, the monuments to various members of the family had escaped destruction, a beautiful marble one to the Doctor (seventeenth century) under an arch canopy attracted our attention.

Finding Allright and I by no means enthusiastic over the great white sarcophagus, our guide launched forth against the College of Physicians a further tirade, which would have pleased the ears of some former correspondents of this Journal.

We had so won the good lady's esteem by our good behaviour and reverential bearing, that she proposed we should visit her Holy of Holies. "Come and see the Doctor's family," said she, leading us into the churchyard, and in a few moments we were descending through a trap door, by a slippery ladder, into a genuine musty family vault. We beheld, lying in rows, over thirty of the departed Harveys, beginning with the Doctor's brother, a merchant of London. "That space," said the old lady, "is where the poor Doctor lay afore those physician people took him up the trap."

The earlier members of the family, children and adults, were cased in lead, which fitted close to the body, giving a shape not unlike an Egyptian sarcophagus; the features of each individual were wrought on the head-piece and the

name with the date inscribed on the breast. The sight was most curious, the children's coffins looking particularly quaint. The old lady insisted on our taking Master Johnny up in our arms—and, indeed, she knew every one of these leaden creatures by name.

On ascending to the free air our guide grew quite eloquent, describing the great folk from the Universities and College of Physicians who had in 1883 assisted at the Doctor's resurrection. They turned the village inside out with their fine robes, horses and carriages; the parson himself, we were even told, was too overcome to make a collection.

Allright, and I, thoroughly beatified, and charmed by our old guide's descriptive ability, took leave of her. She went into her cottage chinking two coins as well as her keys, her heart keeping time to the music.

Next we repaired to the village alehouse. Here, we were acquainted by a confiding potman of a fact sufficiently interesting to those obstetrically minded, *i.e.*, that the wife of mine host had been safely delivered of eighteen children, "all living, all good alike, and without a blemish on their bodies." Had our informant himself been their father, he could not have been prouder of the fact.

This tapster of course concluded that we had come to Hempstead to see the house in which the great Dick Turpin was born, showing us with much pride the green whereon that illustrious man "had done a bit of cock-fighting."

We had seen the door-keeper of the church infatuated with Dr. Harvey, whilst now we hear this servant of John Barleycorn speak with equal reverence of the first "gentleman of the road." We all have our gods here below—even though they be leaden Harveys.

With the end of our pilgrimage comes the end of this, my account, as there is not space, nor is this the fitting place to recount those various curious adventures and discoveries which befel us on our homeward journey.

BEN.

Notices.

FRY'S PURE CONCENTRATED COCOA.

There is no doubt of the fact that Messrs. J. S. Fry and Sons have carried to perfection the manufacture of cocoa, and that the article which they produce is, in every respect, the most perfect form in which cocoa can be taken as a beverage. The samples we have examined are easily miscible in water and milk, and possess a pleasant flavour.

It is well known that cocoa as a beverage is not so stimulating as tea and coffee, but it disagrees with many persons on account of its oily nature. This, however, cannot be the case with Fry's Cocoa, for we find that practically, the whole of the fatty matter has been removed. The generic name, Theobroma, was given to the cacao tree by Linnæus, signifying "food of the gods," to mark his opinion of the nutritious nature of the beverages prepared from its seeds. A cup of cocoa made from the sample received from Messrs. J. S. Fry & Sons, deserves all that can be said of it, in respect of its nutritive properties and facility of digestion.

SALIPYRIN.

Messrs. Allen & Hanburys, Plough Court, Lombard Street, have sent us a specimen of salipyrin, a new remedy for influenza. When administered at the appearance of the first symptoms, it is said to have an absolutely reliable effect.

It occurs in the form of a fine crystalline powder, apparently not soluble in water, but soluble in alcohol. The dose for an adult is from eight to fifteen grains. Professor von Mosengeil, of Bonn, speaks very highly of this remedy. He states that a constant but pleasant bye-effect of the action of salipyrin is the soothing influence it has upon the nerves, and its hypnotic property, as well as its ability very often to remove severe headaches, even such as are not in direct communication with the influenza attack. Eight grains nearly always suffice.

Salipyrin is especially recommended as a remedy against colds and catarrhs. Although the "cold bacilli" are not known definitely, there are probably many different kinds, and salipyrin is an antidote to some very common species, and is itself inoccuous to the system.

In the treatment of chronic articular rheumatism, salipyrin is extremely valuable. In many cases where salicylate of soda alone has produced no improvement, this remedy has given most excellent results.

Review.

Tumours, Innocent and Malignant. By J. Bland Sutton. London: Cassell & Co.

Mr. Bland Sutton has such an easy, chatty style, that it is always a pleasure to read his writings. One can settle down into a comfortable chair, with the favourite pipe, and feel sure of being interested as well as instructed. It requires no strain to follow his arguments, and his descriptions are more pictorial than verbal. With this favourable bias we take up his latest work, and find five hundred pages of large type on a subject of perennial interest to the pathologist and the surgeon. The illustrations abound, for there is an average of one on every other page. Most of them are carefully prepared woodcuts, and a few are coloured plates. In fig. 55 the artist has made a curious anatomical mistake in drawing the interosseous membrane in the leg with its fibres running downwards and *inwards*. He had probably not heard of the famous dissecting room tip.

Turning to the subject matter, we may consider the book from two points of view—what it ought to have been, and what it is. Now as regards the former, every reader will have a different notion, according to what he thinks the title implies or the preface sets forth, and it

may be fairly asked whether a book ought to be judged by its title or its preface. For instance, must we condemn this particular volume because we fail to find "the clinical features and appropriate treatment" of the tumours handled in the way which the preface leads us to expect? We forbear to reply; and seeing that this point of view is somewhat obscured by doubts, we will change our position and prospect. The answer to the other enquiry is less equivocal, for here we have Mr. Sutton as he is known at the Societies, and Mr. Sutton as he may be heard at lectures, and Mr. Sutton as he may be read in the journals, neatly put between two covers—a very excellent "réchauffé" of his numerous pathological contributions. But numerous and brilliant as these contributions have been, they do not cover the whole field of pathology, even of tumours. And there are chapters in this work which lack his special gift, and descend almost to the commonplace. These may be skipped to dwell longer with the mysterious dermoids, the wondrous teratomata, and the incomprehensible cysts.

The mode of classification of the tumours is that adopted by the biologist. There are four principal groups, each divided into genera, species, and varieties. Of course the biological nomenclature is not adopted, so that we are not deluged with new names. As an example of the mode of classification, take the humble fatty tumour, or the genus lipoma, in the group of connective tissue tumours. This genus has no less than eight species, determined by the situations in which the fatty neoplasms arise:—(1) subcutaneous, (2) subserous, (3) subsynovial, (4) submucous, (5) intermuscular, (6) intramuscular, (7) parosteal, (8) meningeal. It seems a pity to stop there, for intracerebral fatty growths have been described, and for aught we know a lipoma may be found in the solid viscera, or the bones. Indeed, may not osteomalacia be regarded as an intraosseous lipoma of the diffuse variety. While taking exception to this topographical specification, it is fair to say that the species of most of the genera are determined by their structure, which is the only reasonable method. Sarcomata form one of the twelve genera of the connective tissue group, and are not specially separated on account of malignancy; while the epithelial group contains both the innocent tumours and the carcinomata. All the so-called infective granulomata are excluded, and Mr. Sutton prophecies that this group will be largely increased in the near future at the expense of the sarcomata and epitheliomata; that is, when the sporozoa have taken their place among the known specifics.

Two separate and elaborate indexes are provided of the various tumours and organs respectively. These will be of great service to the student. And though we cannot say that the beginner will find in this book all that he ought to know about tumours, yet it may be truly said that to those more advanced in the study of morbid anatomy it will prove an interesting and suggestive guide to the knowledge of a very important branch of pathology. T.

The Students' Handbook of Gynecology. Edinburgh; Livingstone.

This little work aims at "brevity and conciseness," and certainly succeeds in its purpose. The author does not declare his identity, thinking perhaps that no great credit would accrue to the compiler of a cram book. Certainly, however, no discredit could be attached to the present venture. The only point on which we would quarrel with the author is this: He claims that the book was designed for those who are *commencing* the subject. Now, beginners would certainly get indigestion from so concentrated a diet. It is surely meant rather for that (by no means exceptional) student who, while reading his subject in detail, gains by the occasional perusal of a digest; especially, be it said, just before an examination. If such an one has been too lazy to make a note book himself, he will find the present little work a very fair substitute. The book contains 49 illustrations, and is well got up.

Aids to the Treatment of Diseases of Children (Medical). By John McCaw, M.D., L.R.C.P., &c. London: Ballière, Tindall & Cox.

It is very doubtful whether condensed notes are ever of much use to anyone but the condenser, and certainly no one who holds this opinion would be led to change it by the perusal of Dr. McCaw's book. The amount of information that Dr. McCaw has condensed into 174 small pages is astonishing, but the very multiplicity of the facts presented is more likely to bewilder and discourage the student than to aid him.

The book is avowedly a compilation, and as such has a value of its own, in that the many methods of treatment which are taken from the different standard works are collected together, and thus can be compared; this, however, is likely rather to prove a hindrance than an aid to treatment, unless the reader has already gained sufficient experience to enable him to select the best remedy for the case in hand.

The author is hardly to be congratulated upon some of his statements. Thus, under the head of infection in measles, he says "that it is communicated by an invisible, infecting principle, such as is contained in the breath and blood, in the form of micrococci, and which may be carried about on clothes, etc., and thus infect others." Or again, under the heading of *tubercular* meningitis, whilst "measles, whooping cough, and typhoid" are cited as predisposing causes, "falls, blows on the head, severe frights, and excessive mental exertion" (in children under twelve years of age!) are mentioned as exciting causes. Again, he commences the description of the treatment of fibroid induration of the lung by advising the student to "remove and prevent any irritation to the lung by colds, etc."

Enough has been said to show that this book can hardly be recommended as a reliable aid in the diagnosis and treatment of children's diseases, for, although there is a very large amount of useful information to be found in it, this must be sought for with discrimination. As is

almost always the case in any compilation, the book contains a very large number of inaccurate statements; this is, doubtless, due to the extreme difficulty of conveying in a short sentence the true meaning of a lengthy paragraph, or, perhaps, even of a whole chapter.

H. J. C.

The A-B-C Medical Diary and Visiting List. London: Burroughs, Wellcome & Co.

This convenient visiting list is to hand. Its contents comprise the usual ruled pages for the daily visits, cash account, obstetric and vaccination and factory inspection engagements, accounts asked for or sent, nurses' and patients' addresses, memoranda of wants and loans, and spare pages for memoranda.

An experience of it for the past three or four years increases our conviction of its usefulness, and, in addition, the Excerpta Therapeutica, which is its special feature (consisting of brief therapeutic notes and doses, arranged alphabetically, of the drugs in general use), will be found a considerable aid in refreshing the memory of the busy prescriber and practitioner, though it unfortunately renders the whole visiting list somewhat more bulky than some of its competitors. To show the increase of therapeutic research in the year, we have only to mention that there is an addition of sixty pages to the 1894 Excerpta since the previous edition (in 1893) was issued.

The list is printed on good paper and published in silk cover for wallet, or tuck cover, with pockets and pencil, at a moderate price.

Sport.

Association Football.

To-day Guy's meet Surbiton Hill in the second round of the Surrey Cup, on our own ground, and as the teams are pretty evenly matched, a great game should be seen.

On this occasion there will be a sixpenny "gate" taken, and we hope to see a good number of spectators down to watch the match. Guy's men will, of course, pass in free on shewing the return-half of the railway ticket issued to members of the Clubs' Union, while those who hold season tickets on the line can obtain passes from the Association captain and secretary—H. Hewetson and R. T. Fitz-Hugh—respectively. The team to represent Guy's will be:—

N. Lavers (goal); F. J. Lidderdale and A. B. Carter (backs); H. Hewetson (captain), N. C. Cooper, and A. E. Crosby (halves); F. E. Walker, B. F. Pendred, R. T. Fitz-Hugh, E. C. Davies, and R. B. Stamford (forwards).

Kick-off at half-past two.

On Wednesday next, January 31st, Guy's meet St. Mary's in the Hospital Cup at Richmond, and if successful against them, meet St. Bartholomew's in the second round.

GUY'S v. NORTH KENT.

This match, played at Honor Oak Park, was merely a preliminary canter for the Hospital in their more important cup tie on the 27th against Surbiton Hill. The game needs little description, as we simply played with our opponents, and ran out easy winners by seven goals to one. The goals were kicked by Davies (three), Fitz-Hugh (two), and Pendred and Walker (one each). The Hospital team was:—

N. Lavers (goal); F. J. Lidderdale and H. D. Packer (backs); H. Hewetson, R. Hayes, and A. E. Crosby (halves); F. E. Walker, B. F. Pendred, R. T. Fitz-Hugh E. C. Davies, and A. Humphrey (forwards).

Rugby Football.

GUY'S v. CROYDON.

This match was played at Honor Oak Park on January 13th, and resulted in a victory for Guy's by one try to nil. Croydon kicked off, and Alexander made a poor return, play settling down in the Hospital twenty-five. The Guy's forwards wheeling the first few scrums beautifully rushed the ball down the ground, but a free kick given against them for off-side brought Croydon relief. The visiting forwards then had slightly the best of the play, but Stewart with a good dribble gained ground, being stopped by Harris, who, with a grand left-leg kick, found touch at the half-way flag. The visiting backs, getting the ball away smartly, almost scored, Turner being brilliantly tackled by Alexander close to the goal-line; Stoker and Slater coming away with a strong dribble cleared the home lines, but on the whistle blowing for half-time, Croydon were pressing.

On re-starting, the visiting forwards, headed by Helps and Marples, carried the ball into the Guy's twenty-five, but a splendid dribble by Mathias transferred play to the other end of the ground. The Croydon forwards continually getting the ball in the scrums, gave their backs plenty of opportunities, but they were prevented from scoring by the splendid defence of the Guy's backs, twice in succession Turner being finely tackled by Alexander when he looked certain to score. Beamish, breaking away from the line-out, was well tackled by Hancock, and good dribbles by Nicholson and Stoker bringing relief.

After some open play the ball was passed to Bell, but he was well tackled by Patey before he could get off. On the Hospital forwards heeling out, the ball travelled smartly from Mathias to Stewart, who, running strongly, passed to Bell, the latter, going as fast as ever, easily scoring near the posts. The kick, taken by Tyson, failed. For the remaining few minutes left for play, the game was evenly contested, and time being called, the game resulted as above. Teams:—

GUY'S.—K. B. Alexander (back); F. Wetherell, H. T. Bell, and H. T. Hicks (three-quarter-backs); R. Mathias and H. M. Stewart (half-backs); F. O. Stoker, L. Slater,

E. D. Hancock, C. R. Nicholson, H. W. Dudgeon, C. D. Edwards, W. Tyson, N. H. Pike, and A. H. Saward (forwards).

CROYDON.—H. N. Harris (back); H. L. Turner, A. P. Patey, and H. A. Flint (three-quarter-backs); H. B. Hubbard and W. N. Kelsey (half-backs); D. H. Helps (captain), N. Marples, S. E. Beamish, F. E. Myatt, H. T. Hipwell, J. D. Walker, S. Ingrams, M. S. Poore, and C. R. Joyce (forwards).

REMARKS.—Alexander's tackling was perfect, and, with Bell, saved his side time after time. Hicks and Wetherell were very safe. Mathias is an acquisition at half. Stewart played considerably off side, but it was a very pretty piece of play on his part when the try was scored. The forwards showed a great deal of improvement in breaking up the scrums and tackling, but they still have a lot to learn in getting the ball in the scrums and heeling out smartly. Stoker, Nicholson, and Slater were the pick.

GUY'S 2ND XV. v. CROYDON 2ND XV.

This match was played at Croydon on January 13th. Our team was very weak forward, and at straight pushing were no match for our heavy opponents, who, directly after the kick-off, penned us on our own goal line. Here the Croydon men lost several good chances of scoring by the selfishness of their backs, until some good punts of T. Morgan brought us a little relief. After about fifteen minutes' play Seymour Hubbard was hurt, and had to retire; and though our opponents still continued to press, we kept the ball for the most part beyond our twenty-five line till half-time.

A weak return to the kick-off let the Croydon men into our twenty-five, and from a free kick for off side, Myatt placed a good goal. This reverse seemed to put more vigour into our play, and our forwards rushed the ball down the ground, where we were awarded a free kick. Though by no means a hard kick, Collins' attempt was unsuccessful. After some more even play, Henry dodged through very neatly, and passing to Moore, the latter gained a try, which he converted. Nothing further was scored, and we thus won an exciting match by five points to three.

All our backs tackled splendidly, while Morgan at centre gained a lot of ground by his punts. Our forwards, though very much out-weighted, did some good things in the loose and tackled well, Lindsay and Goddard shewing up well in this respect. Teams:—

GUY'S.—W. Muriel (back); J. Moore, T. Morgan, and H. B. Walling (three-quarter-backs); E. Morgan and P. F. Henry (half-backs); V. E. Collins, A. J. Cleveland, W. Goddard, G. N. Mottram, W. F. Lindsay, C. H. Fagge, H. Simson, E. J. Spriggs, and Kinsey-Morgan (forwards).

CROYDON.—A. V. Straker (back); S. E. Hubbard, C. M. Goodbody, and H. W. Patey (three-quarter-backs); N. E. Cutler and F. Lucas (half-backs); G. G. Myatt (captain), E. W. Archer, W. C. Myatt, J. A. Fraser, F. Hoare-Ward, E. G. Burr, W. B. Shore, S. Patey, and P. Allen (forwards).

GUY'S 2ND XV. v. ST. THOMAS'S 2ND XV.

On Saturday, January 20th, we played these opponents on their own ground at Lambeth. Hicks lost the toss, and Edwards kicked off against the wind and up the very palpable hill. Scrummages ensued in the middle of the ground, the first three or four being well screwed by the Thomas's men, who were somewhat heavier than ours. Subsequently our forwards succeeded in getting the ball and occasionally shoving the scrums. Our opponents endeavoured to play to their outsides, who were considerably superior to ours, their passing at times being very good. Storrar scored first for Thomas's by picking up in the loose and "bullocking" over. The kick at goal went very wide. Another try was soon scored against us, and on this occasion we presume the referee was looking another way, as the ball was thrown forward beyond a doubt. At half-time, Hicks at last much strengthened our defence by bringing out a fourth three-quarter, for previously we had been playing three against four. At forward, with the hill in our favour, we had the best of the game, always getting the ball and occasionally letting it out to the three-quarters, who, when they got it, generally lost a lot of ground. Hicks made a good attempt to drop a goal, but the ball went a little wide; he managed however to gain a neat try soon afterwards, which Edwards converted into the major. Towards the end of the game Thomas's had another try allowed them, but it was not improved upon.

At the close of the game we retired defeated by three tries (nine points) to one goal (five points). In this match our forwards were the best part of the team, all playing well except in the matter of seldom heeling out *cleanly*. Morgan at half, with the exception of one mistake, played a good game, and Hicks' long kicks were very useful. We were without several of our usual team, but of course we cannot expect them to play for their Hospital when they can watch a match like Newport v. Blackheath! Teams:—

GUY'S.—W. Muriel (back); J. Moore, H. T. Hicks, and H. B. Walling (three-quarter-backs); E. Morgan and P. F. Henry (half-backs); G. N. Mottram, C. D. Edwards, W. Goddard, W. F. Lindsay, C. H. Fagge, E. J. Spriggs, Kinsey Morgan, A. T. Falwasser, and H. A. M. Saward (forwards).

Recent Publications.

Blandford (G. F.). Insanity and its Treatment. 4th Edition. Oliver & Boyd. 10s. 6d.

Donald (A.). An Introduction to Midwifery. Crown 8vo. Griffin & Co. 5s.

Dunglison (R.). A Dictionary of Medical Science. 21st Edition. Royal 8vo. Churchill. 30s.

Galabin (A. L.). A Manual of Midwifery. 3rd Edition. Crown 8vo. Churchill. 15s.

Heath (C.). A Manual of Minor Surgery and Bandaging. 10th Edition. 12mo. Churchill. 6s.

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Guy's Hospital Gazette,

FEBRUARY 10, 1894.

Fracture of the Patella.

CLINICAL LECTURE BY MR. DAVIES-COLLEY.

I HAVE recently had a patient in Cornelius ward, a man of 33 years of age, suffering from the effects of a transverse fracture of the patella, caused by a slip while descending some stone steps. The next day after the accident, after administering ether, I passed a silver wire subcutaneously round the fragments, and drew them together by Barker's method. In less than six weeks the union was firm, and he was able to walk about without any support to the limb.

I propose to take advantage of this case to bring before you the subject of fracture of the patella generally, its cause, diagnosis, and the various treatments which it may require.

Fractures of this bone may be divided into transverse, longitudinal, and the starred or comminuted forms.

Longitudinal and starred fractures are always the result of direct violence. The transverse form may be the result of direct or indirect violence, and it is often difficult to give a certain opinion upon this point. Patients frequently attribute the injury to the blow which they have received upon the knee in falling; but in some of these cases the sensation caused by the snapping of the bone is probably mistaken for a blow. In many cases, however, I have no doubt that the transverse fracture is caused by direct violence. The transverse fracture by indirect violence is usually rather below the middle of the bone. It is due (1) to the enormous power of the quadriceps muscle acting in the semi-flexed position of the knee at a considerable angle with the axis of the patella, and (2) to the fact that in this position, only the middle third of the bone is resting upon the condyles of the femur, while the upper and lower thirds are unsupported. The lower end of the patella is held firmly by the ligamentum patellæ, and the bone snaps across in the same way as you would break a stick by pulling at the two ends with your knee pressed against its middle point. A fracture of this kind is usually a more serious injury than one by direct violence, because it is accompanied by a greater separation of the fragments. In fracture by direct violence the injury is confined to the bone. In fracture by indirect violence the fibrous structures around are torn across, notably the aponeurosis of the quadriceps at the sides and in front of the patella.

As there is only a thin layer of cartilage between the bone and the joint cavity, all these fractures are into the knee-joint. An occasional exception to this rule is a fracture close to the apex of the patella, where some of the subpatellar fat may intervene. Once, also, I have seen a rupture of the attachment of the quadriceps tendon, in which a small flake of bone was detached from the upper border of the patella, and I had no doubt that this small fracture was outside the cavity of the joint.

The *symptoms* of fracture of the patella are that, with some sudden strain or fall upon the knee, the patient feels that something has snapped or given way there. There is pain in the part and soon considerable swelling. He is usually unable to extend the knee or to walk. Once, however, I remember stopping a patient who was stumping out of the surgery with what was supposed to be an attack of synovitis, and finding that he really had a fracture of the patella. The swelling, which is at first caused by effused blood, and later by the exudation of synovial fluid, may be so great that you cannot feel the patella; but this is very rare. Usually a distinct transverse groove of separation can easily be felt between the two fragments. In this, however, there is a possibility of error. Many years ago I found a patient in bed in Cornelius ward, with his leg on a splint, and an ice bag applied, for supposed tranverse fracture of the patella. The diagnosis was due to this groove upon the front of the knee, and I could not persuade the dresser that there was no fracture till I got him to take off the splint and let the patient walk about the ward. The groove was due in this case to some old lymph or recent clot in the bursa in front of the patella; and the mistake may always be avoided by laying hold of the bone above and below, and ascertaining whether the two parts can be moved separately.

It is this mobility of the fragments which is the crucial test of fracture, not only in the patella, but in many other bones. If the fracture is not transverse, its presence and character may be readily determined by pressure upon the sides of the bone, so as to cause tilting of the fragments.

With regard to *treatment*, I shall speak chiefly of transverse fracture. The other forms unite readily by bone, and only require some stiff casing or splint to keep the knee in the extended position for six or eight weeks. In transverse fracture we have two evil results to avoid—(1) non-union or weak ligamatous union, and (2) a stiff knee.

Bony union is rare after transverse fracture, and especially after that form which is due to indirect violence—(1) because the fragments are not in apposition; (2) because the fracture is into the joint cavity, which appears to cause some difficulty in the deposition of callus, possibly from the lymph being too diluted, or from its being washed away by the synovial fluid; (3) from the bone being surrounded on the one side by cartilage and the other side by tough fibrous tissue, so that it receives no help from the pouring out of callus in its vicinity. John Hunter long ago pointed out that when bones are covered by loose connective tissue, the exudation of callus is much more profuse, while bones like those of the skull, which are surrounded by tough fibrous tissue throw out little, if any, callus.

The first of these reasons is the most important one, for we can generally get bony union by keeping the fragments in close apposition. On the other hand, it has happened to me twice, after wiring the fragments closely together by Lister's method, to find that although they remained in close apposition, their union was only fibrous, or perhaps I ought to call it "fibro-metallic," from the influence, I suppose, of the two other causes which I have mentioned. If you can get strong ligamentous union by a band not more than an inch long, the patient's knee will be quite useful for all ordinary work. I dare say he would not be able to win a hurdle race with such a knee, but he can walk and do his daily work as a labourer quite efficiently.

I will first describe the splint treatment which I have found best, and then say a few words upon treatment by operation.

Non-operative treatment.—You should extend the knee and apply a plaster of Paris splint of the kind we call a Croft, from the ankle to the tuber ischii. Keep the patient lying in bed on his back, with his rectus femoris relaxed by flexing the hip thirty or forty degrees, and supporting the limb on a pillow. The pressure of the splint will soon cause absorption of the blood and synovia by which the fragments are kept apart. I have only twice found it necessary to aspirate the joint, and in these cases the patient was in great pain on account of extreme distension of the joint by blood. I do not think that ice-bags or the pressure of an elastic bandage do much good in removing this effusion. In one or at most two days you must slit up the front of the plaster of Paris splint, and, after paring its edges, bring it together with a bandage. If you do not do this pretty frequently, you will find that the splint fits too loosely, as the limb wastes and the effusion in the joint disappears. It is rarely necessary to use any means for approximating the fragments. The various means recommended, in my opinion, do more harm than good. As the effusion goes, the fragments come together in their proper relative position. If you apply strapping and pads to draw down the upper fragment, you will find (1) that your downward traction acts upon the integuments covering this fragment, rather than upon the bone itself; (2) that you tilt its upper part backwards and the fractured surface forwards, and (3) that the integuments below your pressure become swollen, so as sometimes to press backwards between the fragments, and still further separate them. The patient should be kept for about five weeks with the limb elevated. Towards the end of this time he may be allowed to get about on a wheel chair, with the leg on a pillow. He must not, however, be allowed to use the flexors of the hip, but should lift up his thigh with both his hands instead. At the end of five weeks he may walk on crutches with his leg in a sling, but he should wear the plaster splint until about three months from the injury. After that I allow him to walk about with his knee in a support consisting of two laced leather collars, attached by a steel rod on either side, with joints allowing flexion through thirty degrees, and with an elastic webbing in front, which takes off some of the strain of the quadriceps upon the patella. He should wear this till about a year from the injury. As early as five weeks from the injury passive motion should be begun, and later on the joints of the knee-splint should be from time to time filed so as to allow an increasing freedom of movement. By this method it is usually easy to obtain perfect apposition of the fragments in the earlier stages of treatment. If, however, no movement is allowed, adhesions are apt to form and the knee to become stiff. On the other hand, movement and use of the joint cause stretching of the ligamentous union, so that even with the precautions I have described, it will generally be found that some separation takes place when the patient begins to walk about. This separation, however, is so slight, that it does not interfere with the proper use of the limb, and the fibrous band is so strong that if the patient meets with another accident, it is much less likely to give way than the adjacent bone.

Operative treatment.—The great objection to the non-operative treatment is that the patient is crippled for many months, and that, in the case of a labourer, he is practically prevented from working for about a year. If you add to this disadvantage that in a certain proportion of cases, however carefully treated, a stiff or a powerless knee results, you can readily understand why surgeons have endeavoured to shorten and improve the process of repair by various operations.

Two of these I have adopted with complete success. That of Sir Joseph Lister I have already mentioned. The chief objection to it is that it entails much exposure and manipulation of the joint cavity. If, therefore, you should fail in any of the aseptic precautions requisite, you may get acute suppuration of the joint, with all its disastrous results. Again, should the patient meet with another accident, the scar is apt to tear open, and you may get a wound exposing the interior of the joint.

I, therefore, prefer usually to employ the method described a few years ago by Mr. Barker. The instruments used are few, and there is no manipulation of the interior of the joint, so it is easy to secure perfect asepsis. All that is required is a scalpel, a piece of soft silver wire, —one-thirtieth of an inch in diameter, a cutting forceps, and the large curved needle in a handle used for

Wood's operation (N.B.—be very careful to cleanse the needle and its eye). The limb should be washed with soft soap, and a compress of carbolic lotion (one in forty) applied for three or four hours before the operation. The patient being under an anæsthetic, you make a longitudinal incision half-inch long through the soft parts and the ligamentum patellæ into the joint, just below the middle of the apex of the patella. Through this incision you introduce your curved needle, and make it pass behind both fragments, and then, after traversing the tendon of the quadriceps, you should cause it to project above the middle of the upper border of the patella. Here you make another longitudinal incision half-inch long into the joint, and bring out the point of the needle. One end of the wire is now threaded in the eye of the needle, and drawn through from the upper to the lower incision. It is now detached, and the needle is again passed through from the upper to the lower incision, but this time just in front of the two fragments. The lower end of the wire is again threaded and the needle withdrawn. The wire has now been passed completely round the patella, and both ends of the loop emerge just above its upper border. You now draw the ends together firmly, twist the wire, and cut it off close. The blood and synovia meanwhile should be squeezed out of the joint through the two incisions. I have usually finished by closing each incision with one suture of salmon gut. Carbolic gauze may now be applied, and a plaster of Paris splint. The incision heals up in a few days, and I have not yet had any trouble with the wire. I suppose that it wears a groove into the cartilage, and causes no disturbance to the mechanism of the joint.

In one case I used silk with a good result, but I have seen so many silk ligatures in other parts of the body come away some time after the wounds had healed with complete asepsis, that I have preferred lately to use the silver wire. The chief objection I have found to the wire is that in twisting it I am apt to move the upper fragment a little to the right, which causes the fragments to unite with some lateral displacement. In future I intend to draw the upper fragment a little to the left before passing the needle above it, so that my twist may subsequently restore the fragment to its proper position.

Acknowledgments.

The Cambridge Review.
The Hospital.
The Dental Record.
St. Bartholomew's Hospital Journal.

Recent Publications.

Medical Directory (The) for 1894. 8vo. Churchill. 14s.

Morris (M.). Diseases of the Skin. Illustrated. 12mo. Cassell. 10s. 6d.

Richardson (J.). Mechanical Dentistry. New Edition, by G. W. Warren. 8vo. Churchill. 21s.

Hospital News.

In the Surgical Wards.

Under Mr. Howse.

Naaman 9.—E. S., æt. 10. Admitted January 29th for growth on upper jaw and hard palate. Six months ago a reddish spot appeared on the outer surface of the gum opposite where the second left upper permanent bicuspid should be. This has slowly grown inwards over the gum and outer half of the hard palate, and is now as large as a two-shilling piece. It has a spongy-looking, granulating surface, sharply defined from the mucous membrane of the mouth, bleeds readily, is pretty firm to the touch, but near the alveolar process feels as if there were no hard palate behind to back it up, as if it opened directly into the antrum. The hard palate, where it can be felt, is depressed downwards, the alveolar process is bulged outwards, causing a prominent cheek. The teeth are fairly good and regular, except the first left upper molar, which has made its appearance high up on the gum, and looks directly outwards. Nasal fossæ clear; no exophthalmos, and no epiphora. Never any pain.

The date of its appearance coinciding with eruptions of permanent teeth suggested dentiginous cyst, its vascularity, absence of rounded contour, and general character are against this supposition, and it is diagnosed as a sarcoma of the upper jaw, probably myeloid. The bone is to be excised.

Naaman 9.—P. A., æt. 16. Operation for radical cure of right inguinal hernia. In the operation a serous sac was opened first, which extended downwards to the testis and upwards to the internal ring, where it was closed—evidently an abnormally patent processus vaginalis. The posterior wall of this sac had to be divided to gain access to the true hernia, hence three layers of mucous membrane lay in front of the bowel.

Naaman 5.—W. W., æt. 44. Admitted January 28th for strangulated direct inguinal hernia. In the operation the same condition of things was found as in the preceding case.

Both these cases are of interest as examples of a somewhat rare variety of inguinal hernia, known as "Infantile," where an acquired hernia comes down behind an abnormally patent processus vaginalis.

Under Mr. Lane.

Job 22.—C. B. B., æt. 22. Admitted January 2nd, for great pain in small of back on right side, and there is a tender spot on palpating in front, about level of umbilicus. Urine very thick, scanty, and contains considerable pus.

History of present illness.—Patient first felt the pain ten or eleven years ago. Urine was always thickest when pain was most severe. No history of injury.

Patient was operated on the 4th. Kidney was cut down upon and opened, when a quantity of pus escaped

from a cavity. From this led a small passage, which would just admit a probe, into a smaller cavity, at the bottom of which a stone was found blocking the ureter. The opening was enlarged, and the stone removed. The stone was triangular in shape, about three-quarters of an inch long, very hard and crystalline. A glass tube was put in kidney, and the wound sewn up with wire sutures.

5th to 25th. Patient has averaged 16 to 20 ounces of urine, sp. gr. about 1022, acid reaction, urea between 1·4 and 3·6 per cent., always considerable pus. A large quantity of urine escaped through tube.

15th. Tube was removed.

25th. Patient has passed from 36 to 50 ounces of urine, sp. gr. about 1014, reaction acid, urea about 1·4 per cent., still contains pus.

No urine has passed through wound since the 25th, and the edges have united in almost their whole length. Patient has complained of pain in passing water twice, but no stones can be found in bladder.

Patient's temperature has been normal since the 22nd.

ACCIDENT 10.—D. Mc C., æt. 34. Admitted for comminuted fracture of left tibia and fibula December 17th, 1893. The two halves of tibia could not be brought into good position. Put up in back splint with everted foot-piece.

January 4th. Bandages were taken off and put on again.

6th. Decided to operate, as no union had taken place.

8th. Fracture cut down on by oblique incision four and a half inches long; found to pass downwards and inwards for about two and a half inches; two fragments of bone and some muscle fibres were found between the ends and removed. The two ends were brought together with difficulty, by forceps and traction, to within one-sixteenth of an inch of normal position. Two holes were drilled from within and two screws inserted. The wound was sewn up and dressed and leg put up in a trough splint with adjustable foot-piece.

11th. Wound dressed, put in splint again.

24th. Got up into wheel chair.

30th. Croft.

31st. Croft cut up and padded.

February 4th. Patient discharged, leg very comfortable, no shortening, temperature has not been above 99 degrees.

In the Medical Wards.

UNDER DR. PYE-SMITH.

PHILIP 34.—W. W., æt. 21. Admitted January 25th. Three days ago patient felt unwell, had headache and pains in back. The next day he was sick, and there has been constipation from the commencement.

On admission.—A well-nourished strong man; temperature, 103·6; pulse, 100; respiration, 28. Respiratory system normal; circulatory, ditto; urine normal. Alimentary system: tongue furred, no distension of abdomen, spleen cannot be felt There are four well-marked rose spots on the front of the chest, none on the abdomen.

During the next forty-eight hours the temperature kept at about 104, and sponging, which was performed five times only, brought it down about one degree, and it quickly rose again.

On the 27th, at 8 p.m., the temperature being at 104·4, he was put in a bath at 90, which was cooled to 80. This lasted ten minutes, and temperature was then 101·6. It has not been above 103 since the bath, and on February 1st fell in morning to 99·4. On the 3rd it remained at 100 all day.

3rd. His bowels have been open normally since admission. There are now three spots on his back.

5th. Temperature, 99; bowels still normal; is much better; abdomen not distended; no spots. Dr. Pye-Smith remarked on the unusually quick fall of the fever, and says, for an adult, such a recovery is rapid.

MARY 33.—*Vide* GAZETTE of January 27th. By January 27th, in spite of patient's bowels being well open, and diuretic, the ascites had increased, so that Dr. Pye-Smith decided to draw off the fluid. This was done, and five pints five ounces of clear straw-coloured albuminous fluid drawn off. Afterwards the liver could be felt about one inch below the ribs in the nipple line and two inches in mid line. The edge was thin and sharp, and not turned up. The spleen was doubtfully felt; no abnormal lumps could be made out. The character of the liver was against perihepatitis, but the diagnosis was no clearer. Dr. Pye-Smith said it must be some passive portal obstruction.

Patient was more comfortable, and but for some fluid remaining in abdomen, appeared well; but the fluid increased, and the slight bile in urine persisted. On February 4th temperature went up to 101; she was sick three times in night. On morning of the 5th, temperature 103, there was scanty urine with lithates, restlessness, very distended abdomen and tenderness over liver. Dr. Pye-Smith thought acute peritonitis had set in; gave Bismuth, and said if patient was worse on the 6th he should advise exploring and opening abdomen if contents were pustular. Bowels open on 4th once.

PHILIP 38.—Pericarditis and Pleurisy.—R. H. L., æt. 38, is a painter, and was in Philip for a month last summer, under Dr. Goodhart, for lead-poisoning. At this time the impulse of the heart was in fifth sphere, but was palpable in the seventh, outside the nipple; the second sound was reduplicated. While in, a systolic apical bruit appeared for two or three days; and the cardiac dulness is said to have increased much. He went out in July, and back at work in August; but being troubled with weakness and shortness of breath came up and was taken into Clinical on December 14th.

On admission.—A well-made man; he was very weak and orthopnœic. Heart impulse was in mid-axillary line, in the seventh space; the cardiac dulness reached to third rib, an inch to the right of the sternum, and in the left axilla became continuous with the pleuritic

dulness. There was a shuffling sound just below left nipple, and a systolic murmur in epigastric angle. Liver enlarged and pulsating. There were the physical signs of effusion in left chest. Urine was normal. A blister applied to præcordium, and patient venesected.

16th. Two pints of blood-stained fluid were drawn off from left chest.

21st. Nineteen ounces of fluid drawn off. By the 29th he had improved greatly; the cardiac dulness had diminished, and there were still signs of fluid at left base.

January 6th. Patient was transferred to Philip. There was a well-marked pericardial rub, and signs of pleuritic effusion. The rub cleared up about the 20th, but the signs of effusion in left chest remained and increased; so on the 27th sixteen ounces of fluid were drawn off, dark red, with blood. Since this he has improved, and is now getting about. The pericardium is now thought to be free, but that some effusion remains in left chest. Temperature between 99 and 101, higher in evening.

The cause of the pericarditis and pleurisy is unknown. There is no history of rheumatism. The blood-stained fluid points to growth or tubercle; and patient has lost a stone in weight since first admission. Now, however, he is improving, and he is not wasted.

UNDER DR. TAYLOR.

MARY, Cot 56.—H. S., æt. 7 months. Admitted January 26th. Patient came in with congenital syphilis. Father had syphilis. Patient has large square head, no hair, subcutaneous vessels on scalp well marked, interstitial keratitis on left cornea, radiating scars round mouth, small gummatous swelling on right mental eminence of inferior maxilla. Skin is dry and thrown into folds, especially on lower limbs. Brown spots on buttocks. Patient has had the *snuffles*.

Treatment.—Hyd. with Creta gr. i. t.d.s.; Mist. Ol. Morrhuæ with Ferro; Atropine drops (gr. ij. to ʒi.) to eyes, m. et n.

31st. Patient much better; the gummatous swelling burst on 29th, and is now healed. Takes food and sleeps well.

STEPHEN 13.—J. W., æt. 21. Admitted January 29th. Patient had rheumatic fever fourteen months ago, after a wetting; was ill six weeks in London Hospital; remembers the doctors saying "his heart then was not as it should be." No history of scarlatina; no gonorrhœa.

On the 19th, patient, who was then suffering from a cold, had pain in knees and ankles. On 20th, went to work, but felt very unwell. Knees were now swollen, also had pains in temporo-maxillary, wrist-joints, and in back and neck. On 22nd, patient stayed in bed. Now noticed ankles were swollen; these went down in a day or two; sweats now came on, especially at night.

Condition on admission.—Patient does not look ill; sweats a good deal. No pain, except on moving. Knees, especially the right one, are swollen, mostly on the inner sides. Ankle, wrist and finger-joints are rather puffy. Skin over affected joints is neither reddened nor œdematous. Temperature, 100; pulse, 86; respiration, 28; urine, normal. Treatment: Mist. Sod. Salicyl.

4th February. Patient much better; no pain.

UNDER DR. GOODHART.

MARY 12.—F. W., æt. 12. Admitted January 25th. Up to present illness patient has always been a bright child. A year ago it was noticed that she continually dropped things she was holding, and that her hands twitched. About this time her mother noticed that she walked very slowly, as if tired. Patient was in Victoria Park Hospital for six weeks; on leaving she could only just walk home, and that is the last time she has used her legs. Has since been in bed. She gradually became listless and apathetic, showing a disinclination to speak, and now only speaks when spoken to, not raising her voice above a whisper. For about a week she lost power of moving her arms, but this passed off. Bowels have been very confined.

On admission.—Legs quite rigid, but can be forcibly flexed. When stood up, patient stands on her heels. Tactile sensibility is normal. Superficial reflexes are slightly exaggerated. When legs are forcibly flexed knee-jerks can be obtained. Ankle clonus is very marked, as is also patellar clonus. During the day patient lies with her legs extended and rigid; for the last six weeks they have been flexed when asleep; before that they were rigid in sleep. The diagnosis is hysteria, but the case resembles spastic paraplegia in many points.

MARY, Cot 54. — Acute Anterior Poliomyelitis.—C. M. H., æt. 7. Admitted January 25th. Patient quite well until four months ago, one morning woke up feeling sick and unwell, and continued so for two days. When patient got up on third day, her knees gave way, and she was unable to stand. At first she was unable to move either leg, but the right improved so that she can move it and stand upon it. The left leg and foot have remained in same condition. Both legs are wasted, but the left more than the right.

On admission.—Patient is unable to extend the left leg, indicating paralysis of quadriceps extensor femoris, nor is she able to move the left foot, which is in the supine position, indicating paralysis of anterior tibial muscles; no anæsthesia; both knee-jerks are absent; both legs are wasted; the left more than the right; the left gluteal region is more flabby than the right.

PHILIP 10.—Locomotor Ataxy.—S. E., æt. 23. Admitted February 3rd. No history of syphilis. First noticed weakness in legs two years ago, accompanied by pain in the lumbar region. Has gradually become worse, now only gets about with difficulty. Slight anæsthesia over soles of feet.

Reflexes.—Plantar present on both sides. Both knee-jerks absent. No ankle clonus. Loss of power in both hands.

Hearing deficient on both sides.

Eyes.—Pupils react to light and accommodation very strongly; no nystagmus; discs pinkish and slightly swollen.

4th. Pupils of both eyes reacted to light and accommodation.

5th. Pupils widely dilated; did not react to accommodation, and only slightly to light.

6th. Pupils relaxed; act briskly to light and sluggishly to accommodation.

UNDER DR. WASHBOURN.

MARY 5.—G. C., æt. 30. Admitted January 31st, for cough and weakness. One sister died of consumption. Present illness dates from five weeks after last confinement, a year and five months ago. It began with a cough and pain in left side. Has had sweating at night; sputum once or twice streaked with blood. She has also lost flesh; very weak. Four months ago patient had a miscarriage.

On admission.—Temperature 98·4. Patient not very wasted; has a troublesome cough; sputum nummular and streaked with blood.

Respiratory system.—Dulness over anterior surface of left side of chest. Behind, resonance slightly impaired. Bronchial breathing at left apex below clavicle, also broncophony, pectoriloquy, and consonating râles; few râles all over apex. Behind, deficient entry of air with râles over right left side and left axilla; few râles over right apex.

MARY 2.—E. P., æt. 20. Admitted January 29th, for pain in chest and shortness of breath. Has had lumps on right side of neck and submaxillary region; has had winter coughs for several years.

Present illness.—Two years ago patient noticed her appetite failing, followed by loss of colour and getting weak; cough worse than usual; spat more. Improved during the summer. Last winter same symptoms again came on, and disappeared on approach of summer. This winter, cough has become very troublesome. Three weeks ago had a fainting fit.

On admission.—Temperature 99; evening rise. Respiration 26.

Respiratory system.—Subcostal angle narrow; clavicular fossæ well marked. Less movement at left apex than at right; T. V. F. increased at left apex. Dulness in front over left side of chest; cracked-pot sound over second space; impaired resonance over left apex behind. From apex to third space is an area of tubular breathing; few crackling râles; broncophony and pectoriloquy; marked cavernous breathing over second space. Behind, bronchial breathing, broncophony, pectoriloquy, with few râles over apex; bronchial breathing over seventh and eighth spaces; bronchial breathing behind right apex. Sputum muco-purulent with tubercle bacilli; enlarged glands over right side of neck.

MARY 3.—H. C., æt. 40. Admitted January 27th, for loss of power in right limbs. Patient's mother died of an apoplectic fit. History of fainting fits, rheumatic fever, and alcoholism.

Present illness.—January 24th. Patient taken suddenly ill, with a queer sensation. Never lost speech nor consciousness. Has been strange in her manner ever since the attack. During attack left eyelid drooped, left cheek puffed out, left corner of mouth depressed. These symptoms soon passed off.

On admission.—Temperature normal. Patient seems to wander somewhat in her mind. Prominent dilated capillaries over the cheeks.

Nervous system.—Unable to move left arm. Slight movement in left leg. Absent knee-jerk and plantar reflex on left side. Conjugate deviation of eyes to right side. Tip of tongue turned towards left side.

Heart.—No evidence of valvular disease. Heart sounds rather thick.

Urine.—Acid, sp. gr. 1026, contains albumin and blood.

Three Cases of Urinary Calculus.

UNDER THE CARE OF MR. DAVIES-COLLEY.

Reported by Messrs. T. BRICE POOLE & E. NORHAM SCOTT.

CASE I.

B. Mc C., æt. 5. Admitted into Lydia ward 23, on January 7th, for acute retention of urine.

Family history.—Father and mother both healthy. Mother's brother was also troubled in same way when a child, but has improved without any operation being performed.

History of present disease. — Eighteen months ago patient suffered great pain on micturition, and was then treated at the Evelina Hospital. It was then thought that the trouble was caused by worms, as his mother said patient had passed thread worms from time to time. Powders were prescribed, and patient got better. Five months ago the pain again returned, and he was then taken to St. Thomas's Hospital. Patient always pulled the top of his penis on micturition. Circumcision was performed. He had also a left inguinal hernia, for which a truss was supplied and has been worn by patient until the date of admission.

On admission.—Patient was unable to pass his urine, and appeared to be in great pain. He had a double inguinal hernia, which protruded when he strained to micturate, but receded after he had rested in the recumbent position for a short time.

Treatment. — Hot fomentations were immediately applied to abdomen, and Spirit Ætheris Nit. given, but without success. Chloroform was administered, and when patient was completely anæsthetized, he micturated freely before catheter could be passed. Patient's condition then became somewhat serious, and radial pulse could hardly be felt. Legs were raised, and ether substituted, which he took well. No. 4 gum elastic catheter was passed, and very little urine came away. Bladder was washed out with Thompson's fluid, and patient put to bed.

8th. Mr. Davies-Colley passed a Thompson's sound, but could detect no stone in bladder. Patient is frequently passing his water, which gives him much pain. Urine is alkaline, and throws down a deposit of phosphates and pus on standing. Bladder seems to be

in very irritable condition, and is to be washed out with Thompson's fluid daily. Tinct. Belladonna ɱv. was given every four hours. Patient has bad cough, and sleeps badly at night.

20th. As child still suffers much pain, hot belladonna fomentations are being applied to hypogastrium every four hours, the catheterization discontinued, and Mist. Ol. Morrhuæ with Cum. Ferro ʒj. t.d.s. prescribed, as his symptoms suggested that he might be suffering from tubercular disease of bladder.

25th. Patient's temperature rose to 102·4 this morning, and kept above 100 for three days. There is a lot of pus in the urine. His tongue is much furred.

30th. *Operation.* Chloroform was administered. A Thompson's sound was passed, which at once impinged on a stone in the bladder.

The smallest lithotrite was introduced into the bladder and an attempt made to grip the stone. When grasped it shewed a diameter of one inch. There was much difficulty in breaking it, as immediately it was gripped and the screw of the lithotrite tightened, it slipped from between the blades. After the crushing process had been continued for 1½ hours and the stone reduced to a diameter of ⅜ of an inch, Mr. Davies-Colley thought it better not to proceed further with the operation at present. An evacuator was used to wash out the bladder with Thompson's fluid, and the *débris* which came away contained brown gritty and crystalline particles, weighing altogether 80 grains.

31st. Patient passes his urine at intervals of 10 to 30 minutes, and it causes him acute pain in the urethra. Pot. Cit. gr.v. with Tinct. Belladonnæ ɱv. is being given every two hours, and hot belladonna fomentations are applied to the abdomen every four hours.

February 5th. Patient is now much better than before the operation, and has less pain on micturition. He can retain his urine longer, and it contains less pus. The belladonna fomentations have been discontinued. Mr. Davies-Colley intends to continue the lithotrity in the course of a few days.

Case II.

G. R., æt. 6. Admitted into Lydia ward 22, on January 20th, for "difficulty and pain in micturating."

Previous history.—Patient was admitted on July 29th, 1889, under Mr. Davies-Colley, for "phimosis, retention and extravasation of urine."

The report says "The distended bladder could be seen above pubes, and the swelling extended to near posterior part of perineum. Pubic region first became red, then began to swell and was very painful. He passed no water, and a few drops of blood came from urethra. Has had no accident. Penis then three inches in circumference There was not much difficulty in passing a catheter, but there was a slight hitch, probably due to roughness, at junction of spongy and membranous portions of urethra. Mr. Lane made two incisions along each side of pubes and along prepuce. A great quantity of fluid escaped, having an uriniferous smell. No stone could be detected with sound; no rupture of urethra found. Considerable collection of sphegma beneath prepuce. Temperature, 102; pulse, 200. August 11th.—Bridge of skin connecting the two above incisions nearly broken through. Right testicle, which was previously covered with the fascia propria, now covered with granulations. No urine passed otherwise than per urethram. 15th. Patient looks worse; prepuce swollen to five or six times size of glans. Temperature 104·4. September 16th.—Penis getting tied down to scrotum. 18th.—Discharged. No. 4 catheter could be easily passed." Since then patient has had good health, and no urinary trouble until last week.

History of present disease.—Eight days ago patient had great difficulty in passing his water, and whenever he attempted to do so it only dribbled slowly away. Mother brought him to Out-patient department next day medicine was prescribed, which appeared to do him n good. He was brought up to Out-patient department again to-day, when Mr. Symonds sounded and discovered a hard body in urethra, near the bulb. It could also be felt through perineum. There was a little tenderness at this spot. Mr. Symonds thought it was an "impacted urethral calculus."

On admission.—Patient complained of great pain and difficulty in passing his water. Temperature, 100·2 pulse, 112.

The scars of the before-mentioned operation can be seen over and above the pubes. Only the left testicle can be felt in the scrotum. Urine is very alkaline, and contains crystals of triple phosphate and oxalates, a quantity of mucus, but no pus.

January 23. *Operation.*—Chloroform was adminis tered, and a Thompson's sound passed, but no stone could at first be found. There was a roughness at the neck of bladder, which Mr. Davies-Colley thought was calcified mucous membrane. Subsequently, a hard body was felt on introducing a straight grooved staff, giving a distinct ring when the two impinged. It appeared to be located in the neck of the bladder. Mr. Davies-Colley then decided to do a right lateral lithotomy, choosing the right as the testicle was absent on that side, and there would, therefore, be less risk in injuring the right ejaculatory duct than the left. Patient was placed in the lithotomy position, and the staff, touching the stone, was held upright. An incision two inches long was then made, beginning in the middle line immediately behind scrotum, and extending backwards to the right of anus. The tissues were divided on the staff until the groove was found. After the back of the point of the scalpel was introduced into the groove, the handle of the staff was depressed with the scalpel and pushed backwards into the bladder, the points of both staff and scalpel being inclined slightly to the left. In this part of the operation both instruments were held and directed by the operator, being maintained at the same angle to one another. The finger was then passed along the staff into the bladder, and after the staff had been removed a stone was extracted weighing six grains. It was sharply angular, irregular, and slightly faceted.

Mr. Davies-Colley thought it had been lodged in a recess near the neck of the bladder and pushed backwards during the operation. The bladder was then syringed out with Thompson's fluid, during which a hard body was felt to touch the point of the syringe, but nothing further could be found by digital examination. The wound was plugged with iodoform gauze and covered with corrosive sublimate wool. The dressings were renewed frequently, as they became saturated with urine, and during the following night another stone was found in the removed dressings, which had evidently escaped from the lithotomy wound. It weighed seven grains, and was more rounded in outline, very rough, and only slightly faceted.

31st. A little urine now comes through urethra at the commencement of micturition, but the greater part of it still escapes through the lithotomy wound. Temperature this evening, 100·2.

February 1st.—Patient now passes all his urine through the urethra. That passed this morning is very alkaline, and contains a quanity of pus and a little blood. He looks pale and ill. Temperature 99·6.

3rd. Patient is passing urine through lithotomy wound again.

5th. Now nearly all the urine comes through the urethra, but a little still passes through wound. It contains only a small quantity of pus. Patient is looking much better.

Case III.

H. H., æt. 30. Admitted into Luke ward on January 30th, for frequent and painful micturition. Family history not important. Seven years ago patient had Bright's disease, and was in bed for sixteen weeks. Patient has had trouble with his water as long as he can remember. He has had stoppages at various times and great pain, starting at the tip of the penis and extending into the abdomen. Before entering the hospital his bladder was sounded by a doctor, and a stone discovered.

On admission.—The abdomen was much distended, and there was a hard swelling above the pubes, chiefly on the right side of the abdomen.

31st. The abdomen is nearly down to the normal size, patient having passed a large quantity of urine during the night. The hard swelling noticed on admission could only just be felt. The urine was acid, sp. gr. 1010, and contained albumin, mucus and pus, but no sugar. A sound was passed into the bladder, and a large stone felt.

February 1st. *Operation.*—Patient put under ether, and a lithotrite introduced into the bladder. The stone was found too large to crush, so Mr. Davies-Colley decided to remove it by a supra-pubic incision. The rectum was dilated by a rectal bag, and the bladder raised well above the pubes by injecting Thompson's fluid. An incision about three inches long was made in the middle line above the pubes, and the bladder opened by an incision two inches long, cutting towards the apex. The Thompson's fluid escaped somewhat blood-stained. A large stone now came into view. The operator tried to drag it out with his fingers, but failed; it was then grasped with lithotomy forceps, but it was not until the tense linea alba was divided at the upper part of the incision that Mr. Davies-Colley was enabled to extract it.

The stone, measuring $4\frac{1}{2}$ by $3\frac{1}{4}$ by $2\frac{5}{8}$ inches, was so large that great care had to be taken not to injure the peritoneum in removing it; thus the operation was rather a tedious one, even after the calculus had become plainly visible to the occupants of the theatre. The bladder was then sutured to the linea alba, and one suture put through the skin at the upper part. Iodoform was dusted on and a drainage tube tied in. It was dressed with iodoform strips and salicylic wool. The stone weighed exactly 16 ounces.

2nd. Patient quickly recovered from the operation. He was dressed every four hours; dressings were soaked each time, only a slight amount passing through the tube.

3rd. Patient dressed every eight hours. Urine was quite acid. Patient was rolled from side to side every four hours to allow thorough drainage of the bladder. Edges of wound look healthy, no cellulitis. Patient's diet is milk and barley water.

5th. The drainage tube not acting well was taken out. Patient is taking milk only. The wound is looking healthy, granulations appearing. Temperature normal.

6th. Patient on farinaceous diet; he is getting stronger and does not complain of pain.

Calendar of Coming Events.

Feb. 10th.—1st XV. v. Leicester, at Leicester.
2nd XV. v. St. Bart's. Hospital, at Honor Oak Park.
1st XI. v. Maidstone, at Maidstone.
2nd XI. v. Old Wilsonians, at Denmark Hill.
Guy's Hospital Debating Society. Ladies' Night. 7.30.

" 15th.—Medical Prayer Union. Address by Lieut.-General H. A. Brownlow. 4.15.

" 17th.—1st XV. v. Kensington, at Honor Oak Park.
2nd XV. v. Kensington, at Wood Lane.
2nd XI. v. Cricklewood, at Cricklewood.
Physical Society. Clinical Evening.

" 20th.—Hospital Rugby Cup Tie. Guy's v. St. Thomas's.

" 22nd.—Medical Prayer Union. Missionary Meeting. Address by J. L. Maxwell, M.D. Subject, "China as a Medical Mission Field."

Notice.

Vacant Appointment.—Surgical Registrar.

Applications are invited for the post of Surgical Registrar to Guy's Hospital, vacant by the resignation of Mr. A. T. Rake. The duties will commence on March 1st, and applications must be delivered to the Treasurer, Counting House, Guy's Hospital, on or before Saturday, 24th inst.

February 9th, 1894.

The Diagnosis of Diphtheria.

Two cases, recently in the Wards, are, I think, sufficiently interesting to deserve publication, in evidence of the fallacies which may occur in the diagnosis or otherwise of diphtheria. Intense dyspnœa and laryngeal diphtheria in children under five are so constantly associated, that either without the other is worthy of note.

The first case—Bertie J., æt. 5—was admitted under Dr. Pitt on the evening of December 20th, for urgent dyspnœa. He had been ill for two days before admission, having had a croupy cough and dyspnœa, the latter having increased. On admission, the tonsils were large and congested, but no membrane was seen. The cough was moist and croupy. On inspiration, the chest-wall was seen to be sucked in between the ribs, and especially above the clavicles. Auscultation elicited no signs of local disease; there was no albumin in the urine; lividity was fairly well marked; temperature 100.

Patient was given Calomel gr. ij. and enema saponis statim, a linseed and mustard poultice was applied to the chest, and Vin. Ipec. ♏ v.; Pot. Nit. gr. v.; Sp. Æth. Nit. ♏ x., and Aq. Camph. ʒss. was given every two hours. The dyspnœa improved for several hours, then gradually got worse, and at 1.30 a.m. on the 21st it was so bad that tracheotomy was performed. During the operation no membrane was seen; but two or three hours after, a large quantity of mucus was coughed through the tube. This was examined microscopically and cultivations were made, but no diphtheria bacilli were seen. After coughing up the mucus, patient had no further dyspnœa. The following day the temperature rose to 102·4, then gradually came down. 23rd, rubber tube was substituted; 24th, rubber tube removed; 27th, patient could speak distinctly; 30th, wound healed, patient practically well.

The second case—Mary Ann Kitching, æt. 5 months—was admitted under Dr. Washbourn for marasmus, on January 10th. The mother said the child had been in the condition it was for some time, as she had not had sufficient food to give it. On admission, the child was very emaciated, pale, with pinched features. On the middle of the hard palate was a superficial patch of ulceration about ½-in. by ¼-in., and what appeared to be a similar ulcer on the left tonsil. She was given milk, which she took greedily and swallowed *without difficulty*. The ulcers were painted with Mel. Boracis. The following day it was noticed that patient never cried, and, although she tried, was unable to cough. As she vomited the milk, peptonised milk was substituted, and this was retained. On the 12th it was further observed that the nostrils were dilated on inspiration, but there was no evident dyspnœa, and no sucking in of the chest wall. The temperature rose to 102. On the 13th, although the child had been retaining her food, it was evident that she was worse; she was now almost *unable* to swallow. The temperature rose to 102·6; the respirations were quickened; the pulse was 160, and very feeble; the inability to cough or cry was still present. In the evening patient was given some milk, and after the first mouthful she coughed and appeared to be choking, but the breathing became quite free again, the pulse became very weak and quick, and she died with no signs of dyspnœa.

At the autopsy there were two small patches of membrane on each tonsil; and in the larynx, extending from just below the vocal cords downwards about one-third of an inch, was a complete ring of membrane. This was fairly adherent, was detached and washed in two lots of sterilized water. The microscopical examination revealed numerous diphtheria bacilli; and two blood serum tubes were inoculated, which gave pure cultivation of the same bacillus.

It seems fairly evident, therefore, that the membrane had existed in the larynx for at least two or three days before death.

Was the inability to cough, and finally to swallow, due to the diphtheritic poisoning or to the marasmus? and which was the cause of the heart failure which terminated the child's existence? W. C. C. P.

Whiffs from the Smoking-room.

THE LONDON MAN.

"One finds it difficult," said the Club Diogenes, "to average, and to project on one's mental vision, the characteristics of the London University man as we find him at hospitals. The eccentricities of genius, and the fervour of the self-made man, tend to obscure the type. On the one hand, we have the brilliant schoolboy, whose early creeds about 'not wasting time on the Classics and not getting narrowed by a lot of Dons,' have led him to choose the London degree, and to sparkle through the curriculum, till he bids fair to get his M.D. before his moustache. On the other hand, we have the perfervid individual who takes up medicine at the age of thirty, after having been anything else under the sun. Such exceptional beings we constantly find in the ranks of London men, and they tend, as I say, to obscure the type."

"But," added the Philosopher, thoughtfully, "if ever I did see the London type, freed from its fringes, and personified in an average man, it is in yonder individual lunching off a bun and a glass of milk."

"A Bath bun, isn't it?" said the Sybarite, shuddering. (The Sybarite always lunches outside the club.) "It always is Bath Bun and Milk!"

"That," said our Diogenes, confidently, "is out of respect for his WORK. He could, probably, afford other fare, and has almost certainly a good appetite; but even the excellent sixpenny entrée, which is said to be generously provided for us upstairs, would require more vital force for its digestion than can be spared from the profitable afternoon's work which he has promised himself. Believe me, the great characteristic of the London man is his Intellectual Respectability. He is

the Bourgeois of the intellectual world. His knowledge is solid, and in the highest degree respectable. He, himself, in fact, respects it greatly, and is apt to look down (though without malice) on those who have less possessions. It is just the Bourgeois Capitalist all over! I always fancy him going about clothed in his WORK as in a garment—a most impeccable suit of expensive intellectual broadcloth! Just the bourgeois in his Sunday best—all brushed and shiny."

"The suit is apt to fit him ill," suggested the Etonian, "since it is always cut to one pattern."

"Cut strictly to the Syllabus, doubtless," replied the Philosopher, "but, Heaven knows, there's room enough in *that!*"

"I find him very deficient in general conversation," said the Pseudo-Cantab (who, by the way, is really a London man himself). "I shewed him some excellent translations of French Classics the other day, but he has no ideas at all about Montaigne or ——"

The Amateur Medical interrupted here, with some show of anxiety—perhaps from a wish to protect the London man, perhaps from the absence of a wish to hear the Pseudo-Cantab on French Classics. "It may be true," he said, "that our London friend lacks intellectual *nuances*, but it seems to me that he manages to attain to utility, and to an excellent standpoint—I mean as a Citizen of the World. His Point of View is, I think, generally, an enlightened one, while a Cambridge ——"

"Oh!" said the Philosopher, interrupting, with emphasis, "I grant you his Point of View! There, indeed, is the paradox, and, to my mind, the interest of the whole matter. The London man's intellectual stock-in-trade is solid, useful and respectable, but it lacks, as I have urged, distinction and artistic merit; yet, mark you, his attitude towards Affairs is apt to be enlightened. Now, the Cambridge man, though he seldom misses a certain excellence and fineness of perspective in his mental acquirements—has a Point of View which is—well—since I have used the word on the other side—distinctly bourgeois. In the one case it is the brain, and in the other it would appear to be the character which gets forced into the bourgeois mould. It is Experiences, of course, which broaden the outlook, and the London man begins to take his Experiences when he is doing the Prelim. Sci."

"Well," said the College man, "*we* share his experiences."

"Yes, my friend," returned Diogenes, who was now in talkative mood, "but you do not usually spell your work with a capital W. It is the combination which pays. Do not imagine that I have all this time overlooked the discipline of the London Syllabus. It may be sodden fare, but it is wonderful ballast."

"You mean, in fact," interjected the Healthy Philistine, "that the London man is a beggar to work, and at the same time a beggar to go on the spree. I quite agree with you. That's how he gets his Point of View, as you call it."

"How about afterwards" asked the Etonian as the meeting broke up. "Say, for instance, when he gets on the Staff?"

"Then," replied our Philosopher with an air of having much more to say, "Then he is often a prince among teachers; but, for a time at least, he is nearly always tempted to be a High Priest of the Syllabus. But remember, it is not *l'homme moyen* (with whom in all cases we have been dealing) who usually gets on the Staff. 'O.

Pass List, January, 1894.

FINAL CONJOINT EXAMINATION.

MEDICINE, SURGERY AND MIDWIFERY.

*Duffett, H. A. *Leete, A. H.
*Taylor, E. C.

MEDICINE AND SURGERY.

Parry, L. A.

MEDICINE AND MIDWIFERY.

*Burrow, T. *Hoare, E. S.
Drake, E. H. *Lawrence, G.
Miller, W. F.

SURGERY AND MIDWIFERY.

Field, G. H. Miller, A.
Wilmot, P. McK. C.

MEDICINE ONLY.

Barr, V. H. Hopkins, F. G.
Carpmael, C. E. Infield, S.
*Fagge, R. H. Robson, T. S.

SURGERY ONLY.

*Coleman, J. G. B. *Philps, F. G. M.
Hearnden, H. *Reid, E.
*Leathes, J. B. *Simpson, F. H.
*Tuck, E. S.

MIDWIFERY ONLY.

Annis, E. G. *Hovenden, G. S.
Cowan, F. Munro, H. A.
Creak, A. B. *Park, W. C. C.
Culmer, J. W. Roe, E. E. W.

* Denotes completion of examination.

UNIVERSITY OF LONDON.

PRELIM. SCIENTIFIC (M.B.) EXAMINATION.

ENTIRE EXAMINATION.

FIRST DIVISION.

Cazenove, W. R.

SECOND DIVISION.

Clarke, A. E. Durbridge, H.
Parrett, E. E.

CHEMISTRY AND EXPERIMENTAL PHYSICS.

Fox, H. E. C. Harrison, W. W.

BIOLOGY.

Barron, R. M. Dupigny, J. E.
Jensen, E. T.

Passim.

We publish several important letters this week on the subject of Inter-Hospital Teams. We are quite sure, however, that there will be more to follow, and for the present it seems better to abstain from comment on the various arguments advanced. About the Hospital, there has been a good deal of dissent expressed after the perusal of the article in our last issue. Present members of the Cup team seem to prefer to remain silent, so far as our columns are concerned. We hope that if they have any feeling in the matter they will give the Gazette the benefit of their personal opinions.

The Meeting of the Debating Society to-night is to be graced by the presence of ladies, and we sincerely trust there will be a large number of Members present to receive them. The subject of debate is a somewhat subtle point of medical ethics; but, as it was suggested by certain Students from the London School of Medicine for Women, who are likely to be present to-night, we hope that they themselves will inspire our discussion.

In announcing the auspicious event of the coming dinner to Mr. Durham, we spoke as though it would be open to all Guy's men. In this the wish was father to the thought, for it seems that this particular dinner is to be confined to the Durhamite firm. But we are sure that before long arrangements will be made for all of us to share—on some other occasion—a privilege which we should so much prize.

"The patient was doubly unfortunate—first in his injury, and secondly in the date of it. It occurred on Christmas Day, and this, as you know, falls about Christmas time, when there is something else to do besides writing reports in the wards." It was thus Mr. Durham prefaced his clinical lecture on a case of traumatic meningocele, the other day. The report which he next read was, indeed, a curiosity. Having announced that the baby came in for an injury to its head, on December 25th, it remained discreetly silent till January 10th:—"*Family History.*—Father came home drunk, and threw a teapot at the mother, which struck patient on the head." So chronicled this luminous report. Ward clerks would do well to remember that any case may turn out to be wanted for a clinical lecture.

Sir George Humphrey, in an address to the students of St. Thomas's on Methods in Surgical Diagnosis, gave publicity to the following aphorism:—

"Use your—
Eyes first and much,
Fingers next and less,
Tongue last and least."

We are requested to call attention to the announcement in another column that the office of Surgical Registrar will almost immediately become vacant owing to the resignation of Mr. Rake.

We understand that there has, so far, been very little enterprise shewn in the competition for the Treasurer's Prize Essay. For some reason or other the Presidents of the Physical Society have had to deplore this for two or three years past. It is a great pity. We can only suppose that the choice of subject has had something to do with it. Next year the Physical Society might do well to make a new departure and choose a topic of an entirely different nature.

From Messrs. George Philip & Son, the well-known map publishers, the College Library has received a present of a very handsome atlas. We were indebted to this firm some little time ago for the admirable map of London which hangs in the Smoking-room.

The Club has also benefited of late to the extent of a haunch of venison, with Burgundy to match, from one of the most honoured of the honorary members of the Club—the Treasurer of the Hospital.

Four Guy's men—Allport, Alexander, Bell, and Rowland—played for Surrey against Hampshire last Wednesday. Bell put in two tries for the winning side.

Allport was again included in the English team which played against Ireland on Saturday last. It was against Ireland he played in 1893—in the only game which England secured.

We noticed that H. A. Monro ran first in the Lea Harriers' ten mile steeplechase on Saturday, the 3rd instant.

After defeating Surbiton Hill, the Association team have a very difficult task set them at Walton on the 24th, when they will meet the renowned Weybridge combination. Their chance of success will necessarily vary with their form, which, it is to be hoped, will be "Surbiton Hill" and not "St. Mary's."

As Charing Cross scratched to us in the tie which was to have taken place last Tuesday, we pass into the semi-final, which we shall contest with St. Thomas's, at Richmond, on Tuesday, 20th inst. It is to be hoped that a good crowd will be present to aid our team with their cheers.

The third Rugby Football team turned out very boldly at the beginning of the Season, but since then we have heard nothing of it. We hope that matches will be arranged for it for next Season, as there are certainly many men about the Hospital who would be only too willing to play.

First Medical (to Member of Hospital Football Club): "How have you been getting on in your matches lately?"

Second Medical (Member of H. F. C.): "Not so badly, considering that our team generally consists of eight men, six telegrams, and a sarcastically apologetic letter—which mostly arrives the following morning."

This is a "scissors and paste" joke. [Ed.]

Conjoint Board.

ELEMENTARY BIOLOGY.—NEW SYLLABUS.

Candidates will be expected to show a practical acquaintance with the following topics:—

(1) The chemical composition and properties of protoplasm; the structure and properties of cells; cell-division; the general outlines of the varieties of cell-structure in the tissues of animals and plants.

(2) The structure and life-history of *Amœba*, *Vorticella*, *Protococcus*, and *Spirogyra* as illustrative of:—

(*a*) The differences between plants and animals.

(*b*) The general phenomena of the life-history of low organisms.

(3) The structure and mode of life of Saccharomyces and Bacteria; fermentation; putrefaction; modes of spread of Bacteria.

(4) The relations between multicellular and unicellular animals, as illustrated by a comparison of the structure, physiology, and life-history of *Hydra* and *Amœba*.

(5) The *Cœlomata-Invertebrata*, as illustrated by the anatomy of *Lumbricus*.

(6) The *Cœlomata-Vertebrata*, as illustrated by a comparison of the general characters of the skeleton, and of the digestive, circulatory, respiratory, genito-urinary, and nervous systems of the dogfish and the frog.

(7) The structure of ova and spermatozoa; fertilization; the early stages of development; the formation of the segmentation-cavity, of the gastrula, archenteron, and cœlom, and of the epiblast, mesoblast, and hypoblast, with an enumeration of the chief systems of organs derived from the three layers in a Vertebrate.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Year Limit in Inter-Hospital Football.

Dear Sir,—I feel sure most people interested in Hospital Football will have read the leading article in your last issue, on the abolition of the year qualification for the Football Cup, with satisfaction and pleasure, as starting a muchly-wanted movement for altering the suicidal regulations which have for so long hampered and stunted the growth of football at London hospitals.

It is generally admitted that the Cup Tie element was the most important factor in the introduction of professionalism—with all its attendant evils of rough and spiteful play—into the Association game; and it is felt that this element has had the same tendency in the Rugby code, all over the kingdom, obvious examples of which it would be tedious to enumerate. Anyone with a long experience of our own Cup ties must, I think, feel that we hospitals have not altogether escaped from the influence of letting our keenness override our calmer judgment to the extent of indulging in unnecessarily hearty tackling, and too excited determination to win at any cost.

This conviction, however, has been most felt when witnessing any of the less important matches between smaller hospitals, and must have been severely shaken on viewing the much more scientific games, played in the proper spirit and the proper way, which have taken place between Guy's and Thomas's for many years past.

The inference is obvious—the higher the standard of the games, and the more experienced and better-classed the players are, the less the objectionable element of our Cup ties becomes evident; and if by any means we can raise the standard of hospital football, we shall take the very longest stride possible towards removing the one and only objection which can be raised against the many pleasant, exciting, and sporting sides which our Cup ties present to past and present students alike.

There can be no doubt whatever that the proposed alteration of the year qualification must and would go a very long way towards effecting such an end.

It would help the smaller hospitals even more than the larger ones, for it stands to reason that although it must be more difficult to get fifteen men in their year from an entry of one hundred than from an entry of four hundred, yet the number of old men who have played their four years is the same in both cases, no matter what the entry is. So that the smaller hospitals would be brought to a relatively nearer position to those with larger entries.

Two other points I should like to mention, one being that the combination of the teams would be materially improved, and the other, that we so often see a man rise to his best form just as he is out of his year, and when he is old enough, strong enough, and has been taught enough to make him a first-class player, we lose him, and some outside club obtains the benefit of what we really deserve, and what we might so easily keep but for the present absurd restrictions.

In conclusion, I feel sure that our position with outside clubs would be so improved that a hospital team would be an attraction to good University and Public School players, who at present are sometimes apt to be shy of tying themselves down to a hospital in preference to some other club.

Wishing nothing but complete success to the movement,—I remain, yours truly, A. ALLPORT.

Sir,—I was extremely glad to see you ventilate in your last number a scheme for the reform of Hospital Football. For some time I have wished for the abolition of the four-year limit. It may have been desirable in the past, but now, as you say, there is really no necessity at all to make retirement automatic. As an instance, look at our own Hospital from the Rugby point of view; there are eight or nine "Old Caps" about, of them two would have been simply invaluable this year, the others, with perhaps one exception, would not have been worth a thought, and would not have received one by the "Selection Committee"; yet to avoid the difficulty of passing them over, we are condemned to refuse the services of two Internationals. The only other people likely, as far as I can see, to object to the change are, firstly, the "reserves" of this year, who, vulture-like, hope next year to thrive on the losses inflicted by our home-made, suicidal regulations; and, secondly, the smaller medical schools—though I very much doubt whether you and they are right in thinking that the four-year limit creates "an artificial equality between the various combatants." Surely the quicker the circulation of men demanded, the less chance has a small school; and the more the facilities for practice together, the greater chance there is of perseverance producing a good team out of moderate materials? Should the limit be changed from four to five or six, or abolished altogether? I think abolished. The aim we have in view is to enable each hospital to put its full strength in the field—not only against other hospitals, but in all matches. We could and should take a much higher position; the standard of sport at each hospital will go up. Surely you would extend the reform to all branches of sport? By all means let Rugby Football prove its right to be considered the premier sport of the hospitals by taking the initiative—the sister sports will soon follow; and not till then will the medical students of London take the high position among London teams which they are capable of doing, and which they have been debarred from doing by this suicidal rule.—I am, yours &c.,

AN OLD CAP.

Dear Sir,—Was it a very long time ago that it was ordained that no man should be considered fit to represent his hospital after four seasons? If so, why was it? Was it because, after that time, a medical student

(old style) usually became unbearable; or was it because the curriculum only then extended over four years? Or, was it because we thought it big to ape the 'Varsities? Or, was it for either of the reasons you suggest? Or, lastly, was it (like most things) for some unknown reason. My own belief is, that the rule was foisted on us in our blindness by some kindly external power, who saw in us a good nursery for young blood, and in his own club a good permanent flag for the skilled man to play under, and in our youth a means to an end.

By all means let us awake now, and see that hospital football must go up—for better class sport means better men all round, and better men means better doctors. So you see it is a duty we owe to humanity.

I am, yours faithfully, FORWARD.

SIR,—That the question raised in the columns of the GUY'S HOSPITAL GAZETTE is one of importance, and fraught with changes worth the attention and consideration of every hospital footballer, there can be no manner of doubt. Since the article appeared, therefore, much comment and many different opinions have been as freely given as offered, on a subject of such vital interest to us all, and I have thought that some of these opinions, if expressed in a letter to you, might prove of some value in the critical consideration of hospital sport as it is. The tone of these critics is antagonistic to the views so ably expressed in your pages a fortnight back. First, then, to deal with the arguments laid down by you. With regard to that "striking at the very existence" of international cup ties, it has been unanimously agreed by our side, that this very objection (which you do not believe to be valid) must come to pass if a year limitation were done away with. We contend that smaller hospitals would never agree to the change, and that, as a consequence, the larger hospitals would break away from the contests, such a step inevitably destroying the value and interest which at present is undoubtedly held by all.

Then, in considering argument number two—that the regulation excluding senior men from playing cup ties tends to make the teams inferior to what they might be without cup ties—we entirely disagree. Are you supposing that we have the senior men always with us? That it is possible for a hospital team to do great things, may I remind you of Fripp's year, when such clubs as Blackheath, London Scottish, Rosslyn Park, Old Merchant Taylors, etc., were defeated by Guy's? Or again, of the things that St. Thomas's have done against first-class clubs? Inasmuch, too, as the year limit is now altered to five years, there are many who think that senior men may be played out at the end of their time. It is a well-known fact that the character of a man's play varies, to a great extent, from year to year. One year he may be in his prime, the next year worthless, and, consequently, *not* wanted; and none but selection committees know how difficult and delicate a matter it is to convince such a man, when once he has played in the cup team, that he is not necessarily a member for life.

Then, Sir, with regard to this point, you have made an obvious omission, the consideration of which is at the very root of that *esprit de corps* and good feeling so characteristic of a hospital team. If you cram your team with senior men, how are you to deal with your "Freshers"? No "Fresher" could reasonably be expected either to be keen on hospital football or to refuse to play for outside clubs, when his chances of getting into the Cup team are minimised to such an extent as must necessarily follow from the introduction of a "no limitation" regulation. It may be true that the backbone of a team lies in its seniors; but through neglecting to foster a spirit of emulation and keenness among the juniors, where is a captain or committee to turn for help in the hour of need? With such a system sooner or later a crash must come, and the last state of the club is worse—very much worse—than the first. To make this objection more convincing—if such a regulation as you propose came into force, there would be no need of a selection committee composed of different years' men, and it is quite likely that its constitution would remain the same for, say, six years! Anyone who has had anything to do with selection committees must appreciate the very great difficulty that even the most conscientious have in selecting *without prejudice*. Supposing such a state of things did exist, it is possible to see hospital football dormant in the hands of a terrible clique; and that is what we should dread above all things—the formation of a closed ring.

Another point that has been overlooked by the writer of the article is this: He proposes to make "the best team that each hospital could put in the field its Cup team," by abolishing the year limitation; though he characterises as absurd the likelihood of "ancient heroes" being brought from their practices to play—a policy, as he suggests very rightly, to be suicidal—a line must be drawn somewhere. In our own case, we have several old footballers always with us—it is not impossible that these might be chosen to play even when they had become members of the Staff!

Finally, a very strong conviction is held by many men that hospital football is on the upward rather than the downward grade; and certain it is, at any rate at Guy's, that now we have a football ground that—thanks to the energy bestowed on it by the officials of the Clubs' Union—is one of the best in London, and men continue to use it for purposes of training, there can be no fear of a deterioration either in the style or character of the hospital game in the future.—Yours truly, RUGGER.

Lying-in Charity.

DEAR MR. EDITOR,—During the month of January, out of two hundred and ninety-three cards attended, over eleven per cent. of them had been given to women living outside the district specified. I, myself, had over fourteen per cent.—in one night doing three in succession. This may appear at first sight to have arisen through

misleading statements made, but that this was not always the case was apparent from notes entered on the cards, such as, "just out of district," etc. In fact, so tedious did the continual writing of such sentences evidently become that finally it was abbreviated into "o.o.d."

Had the chief offender in this direction thought of the weary trudging thus entailed, rather than allow his breast to expand with love to the coming race, he would have gallantly stood by the very fair agreement such a charity makes with the public.

Returning from one of these many outings, the following occurred to me, and with your permission I will submit them:—

(1.) This issuing of cards can hardly be considered as in any way a medical education, and I would suggest that, as it is purely office work, possibly arrangements could be made for carrying it out directly from, say, the Superintendent's office. Thus one person would soon become *au fait* with all the twists and turns, and not, as at present, when this excellence is reached be superseded by an inexperienced hand.

(2.) That the paragraph on card with reference to non-attendance at addresses other than those stated be made more emphatic, and this part be printed in bolder type, together with a note *re* cards obtained for addresses beyond radius.

(3.) I found it would have, in many cases, been useful to bearer had the address to which card had to be taken been stated.

(4.) The large charity map would be more useful were all the alleys and turnings to have their correct names entered either directly or by reference number to a list.

Should anyone not agree with Sir Andrew Clarke in his estimate of women, he has only to do a month's extern in order to alter his opinion.

EXTERN.

Guy's Hospital Rifle Association.

THE above will commence operations for the current year in the course of March, and all men intending to become members are requested to do so at once. The annual subscription is five shillings, with an entrance fee of one shilling for new members, and may be paid to any member of the committee, viz., Messrs. Telling, Sells, Ashwin, Fulton, and Winter.

Doubtless many new men have served in cadet corps and are already familiar with the use of the rifle, and these are especially requested to communicate with the officers with a view to the early formation of the teams for the season.

Matches with various teams will be arranged for the summer months, during which there will be in addition accommodation for practice and prize competitions.

The range is at Ilford, to which there are frequent trains from Liverpool Street, G. E. R.

Any further information may be obtained from the Secretary, H. FULHAM-TURNER.

Pavy Gymnasium.

THE Annual Boxing Competition will be held on or about February 28th or 29th, and is open to all members of the Pavy Gymnasium and of the Clubs' Union. The following weights will be decided: Under 9 stone; under 10 stone; and any weight. It is hoped that a good entry will be secured, to afford a good selection for the United Hospitals' Competition in March.

The Annual Fencing and Gymnastic Competition will be held in March, and, as usual, will consist of set exercises on the horizontal bar, parallel bars, and vaulting horse. Squads will be selected, and prizes presented to the men obtaining first and second places in the competition. Practice in the exercises will be commenced on Tuesday next, when all competitors and others are requested to attend.

At a Committee meeting of the Pavy Gymnasium, held last week, the following resolution was unanimously passed: "That this Committee, on behalf of the Club, desires to express its best thanks to Dr. Pavy for his liberality in supplying the Pavy Gymnasium with fencing foils, masks and jackets during the present season."

Guy's Hospital Dental Department.

PRACTICE DURING NOVEMBER, 1893.

Gold Fillings	219
Amalgam ,,	260
Osteo ,,	
Perm. G.P. ,,	
Temp. G.P. ,,	236
Artificial Crowns	14
Dentures	7
Scalings	14
Dressings	—
Attendances for Extractions under Anæsthetics	391
,, ,, without ,,	393
Advice	—
Total	1534

PRACTICE DURING DECEMBER, 1893.

Gold Fillings	230
Amalgam ,,	406
Osteo ,,	
Perm. G.P. ,,	
Temp. G.P. ,,	231
Artificial Crowns	15
Dentures	11
Scalings	24
Dressings	—
Attendances for Extractions under Anæsthetics	258
,, ,, without ,,	301
Advice	—
Total	1576

How should we study Medicine?

THE LECTURE INTRODUCTORY TO SESSION 1868-9, AT GUY'S HOSPITAL.

BY WALTER MOXON, M.D.,

FELLOW OF THE ROYAL COLLEGE OF PHYSICIANS.

(Continued.)

All the Faculties follow the same sort of stages more or less, nowadays. You will needs be made up piecemeal, whether you like it or no. You will be put together, like a plaster image of a not over-definite figure—first legs, then body, then head; and by the time the head comes, the chances are, the body and legs will be crumbling away.

Now, all this meanwhile—mind you don't lose the independence of your judgment. The medical council (like Frankenstein, in the story) will mould you, as best they can, into the image of such a man as they want; but you will supply the soul to it. And perhaps you may, like Frankenstein's image, teach them to be less ambitious in their creations.

Take care of your freedom, and, with all your getting, get understanding. Understanding is the organization, the digestion of your knowledge, the mastery of it, so that you are in possession of its central and cardinal points, its seats of government and control.

What we want you to do is, to inquire into, and grasp intelligently, the principles of every science you study; you will not keep all the details, but, when the details fall like leaves, then the principles shall remain, as the stem, and boughs, and branches, to give form, and strength, and permanency to your tree of knowledge. Let over the door of memory be written, "Nothing unmethodized enters here." Don't cram with ill-arranged knowledge. Don't cram for your examinations. The examination is not your real trial; you only find *bail* there to appear again before a higher court, where your worth and usefulness will be vindicated or condemned without appeal. DON'T CRAM!

It is pitiful to see those poor creatures who, without putting out vital power of mind, suck, and imbibe, and swell out into shapeless lumps of unorganised learning which dies down and decomposes in them, till they go about putrescent heaps of decaying knowledge, on which theories, and —opathies, and other low growths, sprout and flourish like funguses on a dunghill. Don't cram. Don't fear your examinations. A wise examiner does not "pluck" for what you don't know; but for mistakes which show confusion and error in principle. Don't suppose you can "get up," in the last few months of your study, such a knowledge of principles as will save you from confusion and error. You can't. Consider the limits of your acquiring intellect. Your intellect cannot take photographs; it is just one single individual indivisible point, that, like your discerning vision, can only attend to one thing at one time.

Your intellect, like a single pencil point, will go, throughout each day, over the page of memory; and it will write deeply and durably, as attention keeps it down firmly. Please let it now write down this indelibly:—*Bad Memory is another name for Inattention!*

Now, see that, with this one small single point, you have slowly and perseveringly, and with much reiteration, to trace out a vast chart of all the dangerous places that the sick pass into; and by this chart you must pilot your patient, and no one can get at that chart to improve it but yourself only.

And, when I think what vile, futile daubs and scratches, untrue to the real dangers, some fellows make, one would almost wish they could sink with those whom they mislead into the quicksands—pilots who drop the anchor when all is safe, and rush on among the reefs.

I wish I had time to go over the several branches of your study, and consider the special service of each. But this is scarcely the occasion for such detail. Every teacher will impress his own "science." To-day our common care is, that we enter on our labours with a spirit equal to the achievement we forecast; we look at the end, and gather up our strength.

Yet I will go out of my course to recommend you a special study of anatomy. Not because you will have to cut off legs. You don't think of anatomy when you are doing that; you cut, and saw, and tie what bleeds. But because the knowledge of anatomy is the type of the knowledge of disease, and practises your minds in retaining complicated matters of fact which have no casual connection. So, set yourselves to get a good practical knowledge of anatomy; for the process you will get it by is a very difficult process, and wants immense practice; and it is the only process by which you can learn disease. That process is, direct original observation. It is as easy, and as dangerous, to do this badly, as it is difficult and triumphantly efficacious to do it well. Learn, in the study of anatomy, to use your senses for yourselves, and not to rely on books or lectures. If you look at this bone, you get an image, a sort of shadow of it in your minds, that you can remember and recall. That image is all the teacher has got himself; and when he goes to give you over his image, or shadow, he can't send it out bodily, like this bone does, to your eye; he has to try and carry over to you a sort of shade of his shadow by a piecemeal of words, every one of which is either too large or too small for what he wants it to carry. Don't take piecemeal the shades of another man's shadows. Go to Nature direct.

The lecture and the book do this for you; they give you names to communicate what your eyes see. They teach you the meaning of the name: your eye must teach you the nature of the thing. They cannot replace your direct observation.

The best lecturers are those who draw good outlines in chalk; but the outline on the bone itself is better. See it. See it well. But, to equal the lecturer, you must see it, not as an ox sees fodder, but analytically. Note its parts, and complete the register of its form in all details

in your memory. Then you shall be independent of Ellis and Holden, and you shall examine your examiners! And what is more by far—you shall be ready to learn with equal directness the facts of disease. You shall be free-born in the noblest of all vocations. You will have always near you a self to trust when there is no one else within reach. By direct skilful observation you will acquire a most valuable knowledge of diseases; and you will see for yourself what can be done, and what can not be done, for their relief. But if, instead, you take to Medical Literature, *nihil sanantibus litteris*, you will find it voluminous enough. Medical Literature is immense in quantity, but in it is much chaff and little wheat. When what is known is little and unsatisfactory, and what is NOT known is much and promising, then the tendency is almost inevitable to turn from the little that is known, and make guesses about the greater unknown. And the guess is one's own, while the facts are anybody's; so the guess is fostered with a parent's love, and decked out with all a parent's fondness, and smiled over by polite friends; and presumptuous facts, that don't give way before it, are snubbed; until at length, alas! its lightness of character brings it to appear where it disgraces its parentage; and, though the offspring of an F.R.C.P., it is found plying a shameless trade among the nauseous advertisements in the public daily press.

Knowledge of facts got by reading is practically worth nothing. See the real use of reading. The only use of books is to instruct you in the meaning of a name. Your own eyes, and ears, and touch must teach you the nature of the thing. Medical Literature, when it goes beyond what you can see for yourself, is full of vain strife and contradiction. I am ashamed to think what amazing contrarieties of views and statements will be set before you when you study Medicine and Surgery. And I want to show you how you are to test these opposite teachings. This is the only way:—By getting such a practical knowledge of what they are all about, that you know what the writer can know, and what he cannot know. If you thus know the things he speaks of, you can be guided by this sure rule, which please write down.

Never trust a man for what he cannot know.

If we followed this simple rule, "Never trust a man for what he cannot know," then there would be an end of quackeries, and theories, and —opathies. But the mass of our profession are so unnecessarily second-hand in their knowledge, that they don't know what can be known and what can NOT be known. We all have to face much confusion; and few people are able to face necessary confusion, and act quietly up to what sure light they have. They cannot overcome the human tendency to meddle with what they don't understand. And then confusion can be offered, by clever people, in a sort of clarified form, which is liked better; and if the mass of confusion is great, nearly every one is satisfied if it is made transparent at the edges. They are too idle, or, as they call it, "too much occupied" (which is always the same thing), to go into the middle and examine it. They prefer to be guided by faith, and not by reason. Gentlemen, your faith may lead you, but your reason must guide you. *Your reason should be behind, but above your faith*—for our oracles are uninspired; while there is truth in Nature to be found of all who seek of her direct.

"But," you say, "What of our progress?" True! Gentlemen, the medical profession has made a deal of what is called "Progress." Beware that word. There no such thing as Progress, except for conveyance from place to place. All improvement is development. Progress is a leaving of what is behind, and a pressing forward to some mark. But we must not leave what is behind; and we have no mark to press to. If you turn to those few great medical discoveries which we daily find true to Nature—Vaccination, Bright's disease, Addison's disease—you will see that they were not made as "progress," but rather as backward steps to old, simple, natural truth, which had been neglected or forsaken because such sober truth did not suit the big hopes and wishes of some chimerical aim.

All along, it is this finality, this pursuit of chimerical aims, that has stayed our development. It is because Physicians have looked rather to great, vain aims, than to the facts of Nature, that we have so few general truths, and that we neglect so much those we have. It is because, when the facts do not directly promise the fulfilment of the aim—we look more to the aim and less to the facts—that our medical press contains so few accurate and simple observations, and contains instead so many futile guesses at the nature and treatment of some undefined disease or "Theories," as they are called. They are only guesses in live English. Don't waste your time on these theories.

Medical theories are short-lived creatures, made out of a little dust of facts, in themselves lifeless, which some one fashions into a shape, and breathes into it a little puff of himself—a breath of life that's not Divine; so that they soon fall to pieces again, when they have served their maker's purpose. And the relics of these wretched broken-down theories are blown about the ever-shifting desert dust of medical literature; or else they stick about the little bits of real truth, in the shape of obsolete names and false descriptions—hiding the truth, as when those old accumulated shells of other years stick together round a very old oyster, making it such a task to reach the oyster himself, however ardently you desire to eat him.

The people who make these theories are straining after impossible aims; and not making sure their steps to what is really obtainable.

They look soberly only on conclusions, and—if I may so speak—are drunk on the premises. They draw conclusions, when they should know that conclusions which have to be fetched are not worth the having. In their haste to anticipate the natural development of inquiry, they are like children who poke open buds in a hurry to have flowers.

But do you, gentlemen, habituate yourselves to suppress guessing. Let your language in diagnosis express only the ascertained truth of your knowledge of the case. Be ashamed of a guess. A guess is the cry or squeak of an overstrained reason. It is as difficult to keep from guessing when you are in doubt, as from crying when you are in pain. Doubt is the agony of reason. You must learn to bear it, and to act calmly under it. If your courage gives way, and you squeak out a guess, it will no more help your reason than cries lessen pain; but, like the cries, it will occupy you uselessly, when you might be helping yourself really.

Don't make guesses falsely respectable by calling them "Theories." Call them "Guesses"; it is better English. Let us say, "Dr. So-and-so's Guess about So-and-so." Keep away from these guesses and discussions of guesses. If you for yourself first learn to be scientific, and then observe the nature of diseases patiently and well, you will see what can be known, and what cannot be known; and you will be kept from the greatest danger of generous minds, which is this: that in striving to know what cannot be known, they leave unknown what they might know. Watch patiently the practice in the wards—surgical and medical—that you may learn the course of disease, and see what can and what cannot be done for their relief, and get experience in doing what can be done.

(To be concluded.)

From the Gazette's Special Pathologist.

W., COLCHESTER.—Fluid is faintly alkaline and contains 1·8 per cent. of urea. Alkaline fermentation has taken place, with precipitation of acid ammonium urate. No other pigment except hæmoglobin could be detected by the spectroscope. The hæmoglobin was thoroughly dissolved in the water present. The proteid debris was too far changed to admit of a determination of the presence of red corpuscles. There were several epithelial cells present, but none of uterine or a malignant type. The above points to a kidney origin of the hæmoglobin; but whether the case was one of hæmoglobinuria or simple hæmorrhage would be difficult to decide, except by examination of a fresh specimen.

W. H. M., KIDDERMINSTER.—The rectal growth is a spheroidal-celled carcinoma, with a well-developed fibrous stroma.

H. L., SALFORD.—The breast growth is a glandular carcinoma, and shows mucoid change in the surrounding fibrous tissue.

E. W. W., HITCHIN.—The specimen is one of glandular carcinoma originating in the ducts. There are numerous cysts.

E. R. M., HASTINGS.—Numerous tubercle bacilli.

F. R. A., SHERBOURNE.—Tubercle bacilli present in no great quantity.

X., FAVERSHAM.—No tubercle bacilli recognised.

W. E., CARDIFF.—No tubercle bacilli found.

W., HASTINGS.—No tubercle bacilli found.

PATHOLOGIST.

Specimens for examination and description in this column, should be addressed to H. HUNT, GAZETTE, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

Review.

Aids to Otology (second edition of *Epitome of Ear Diseases*). By W. R. H. Stewart, F.R.C.S.E. London: Balliére, Tindal & Cox. 8vo, pp. 110.

In the preface, the author says:—"It should be distinctly understood that this book is in no way intended to take the place of the larger works on ear disease." On this point we agree with him; we do not think it will.

The "Aid" series are like the "Tablets," a short and very bad cut to examinations—at least, to judge by the results. As far as otology is concerned, we fail to see any object in compiling these pages, since this branch of surgery is not made much of at examinations. A few men, it is true, do take the trouble to learn something about the subject, but often when there is nothing else that appears to them worth doing.

We cannot imagine the possessor of this little book gaining any serviceable or practical knowledge from its perusal. Of what use is it to compile lists of causes—lists which are strung together without the slightest attempt to estimate the relative importance and *modus operandi* of any one cause? Take, for instance, acute inflammation of the middle ear. No less than twenty-eight possible causes are enumerated, with an "etc." at the end. Collapse and obstruction of the Eustacian tube are assigned to twenty conditions, one of which is "any weakening disease."

The physiology of the ear is packed away into twenty lines, and disposed of under two headings, one of which—the sound-receiving portion—has the sole merit of brevity in its description: "It is a complex nervous system." For the individual opinion of the writer in various disputed points we look almost in vain. We are told, however, that the "author once had a case in the sixth month of pregnancy; after politzerisation, she went home and miscarried." We fail to find any acknowledgment of the good work done by our surgeons in mastoid disease and caries of the temporal bone, although the book appears to consist largely of other people's opinions.

To sum up, we regret sincerely the publication of such an "Aid." It is a distinct obstruction in the path of rightful knowledge, and is but too likely to bring into contempt a subject which is already sniffed at—be it said, however, by those only who do not care to know anything about it. For those who do care to work at it, there is wide enough field for investigation.

A. H. T.

Sport.

Association Football.

SURREY CUP.—SECOND ROUND.

GUY'S v. SURBITON HILL.

This match was played at Honor Oak Park on January 27th, and notwithstanding the inclement weather was watched with interest by a fair number of spectators, among whom we were pleased to note the faces of our popular Dean and Mrs. Shaw, and Drs. Washbourn and Fawcett. An Oxford Soccer Blue was also among the "crowd."

Both teams were fully represented, and Surbiton winning the toss, Fitz-Hugh kicked off towards the Pavilion goal in the face of half-a-gale of wind. For the first ten minutes Guy's did all the pressing—the Surbiton men not having got into their stride; at the end of this time, being aided by the wind, they gave our backs plenty to do, but Lavers was always in the right place for any shots that came into the goal mouth. He made one particularly good save—a high dropping shot—although he had two or three of the Surbiton forwards upon him. Our forwards, too, made frequent dashes towards the Surbiton goal, and the passing was fairly good considering the wind. Stamford, Davies and Fitz-Hugh all made good attempts to score, but Carter saved splendidly on more than one occasion. At length Guy's forced a corner, which Hewitson took, and dropping it well into the goal, Stamford put it through; but, to nearly everyone's disgust, the referee disallowed it for off side. However, we managed to keep them from scoring, which was as much as we could expect playing against the wind, and so half-time came with the score sheet blank.

On crossing over we soon began to show signs of superiority, and gave Carter a pretty anxious time. The second half had not been in progress very long before Davies got possession, after a good run by our right wing, and with a neat shot scored the first goal for Guy's, to the great delight of our supporters. Surbiton now went at it in earnest, but found Cooper a little too good for them, and he and the other halves quickly broke up the attack of the opposing forwards; in addition to this they all had shots at goal, and it was from a splendid effort of Hewitson's that we scored a second goal, Carter fisting it out hard on to Davies' chest, whence it bounded through the posts. After this Guy's slackened off a bit, but still had all the best of the play, and so the game went on until Davies for the third time put the ball through by means of a grand shot which struck the crossbar and went through. For the last quarter-of-an-hour play was more even, but Carter and Lidderdale—who had played splendidly—had no difficulty in keeping them out, and when the whistle went Guy's left the field winners by 3—0. Of the players N. C. Cooper was the best man on the field, and it was in a great measure due to his grand play that the Surbiton attack was so weak; however, all the team played well, especially Davies, who not only got all three goals but played a dashing game all through, and gave the Surbiton backs a lot of trouble. For Surbiton, Carter and Jupp were easily best, and had it not been for their sound play we should have won by a much larger score. Teams:—

Guy's.—N. Lavers (goal); A. B. Carter, F. J. Lidderdale (backs); A. E. Crosby, N. C. Cooper, H. Hewitson (Captain), (halves): R. B. Stamford, E. C. Davies, R. T. Fitz-Hugh, B. F. Pendred, F. E. Walker (forwards).

Surbiton.—E. Carter (Captain), (goal); H. Jupp, T. P. West (backs); K. Bremner, E. Young, H. F. Smith (halves); H. Large, H. J. Bryant, T. Stevenson, H. Firmin, C. J. Rooke (forwards).

GUY'S v. ST. MARY'S.

Second Round of Inter-Hospital Association Cup.

This match was played at Richmond on Wednesday, January 31st, before a large and enthusiastic crowd of Mary's men. Our team—alas! that we should have to record it—failed somehow to give us as brilliant a display as that which we witnessed on our own ground against Surbiton Hill in the second round of the Surrey Cup, although several times during the match, and especially during the second half, there seemed reason to hope that the result of the match would have been otherwise than it was. Too much praise, however, could not be bestowed on the back division of the team, who one and all played a sound and determined game. Our forwards, on more than one occasion, managed to get together, and made some good rushes towards our opponents' goal, but their efforts seemed to die away at the critical moment, and we must confess to feeling, as we sorrowfully left the field, that a trifle more dash on their part might have changed defeat into victory.

Coming to the details of the match. Guy's lost the toss, and Fitz-Hugh kicked off against the wind. Mary's shewed the better combination at the start, and for the first quarter of an hour play was chiefly confined to the Guy's quarters, and our backs were busily employed, but proved equal to the occasion. Guy's then pulled themselves together, and play became more even, Walker shewing up to advantage on the right wing, while later Fitz-Hugh put in a magnificent long shot, which their goalkeeper just managed to save. About this time the game had to be stopped for a few minutes owing to a collision between Cooper and Squire, the latter receiving a nasty cut on the forehead, notwithstanding which he pluckily continued. Several corners now fell to Mary's, whose forwards were playing the stronger game, and Lavers was several times called upon to save, which he did in his usual effective style. Half-time arrived, nothing having been scored by either side. Guy's now had the wind in their favour, and our forwards, putting in some good work, and being well backed up by the halves, several times placed our

opponents' goal in danger. Stamford, who was most conspicuous of the forwards, made one or two good runs and put in a good shot which their custodian had some difficulty in stopping. Several good opportunities of scoring, however, were lost by the strange incompetence of our forwards in front of goal (the old fault), Pendred being the worst offender in this respect. Mary's now getting away, from time to time gave Lidderdale and Carter some trouble, and on one occasion, about twenty minutes from time, Sworder, making a fine run down the left wing, centred well, and—a scrimmage ensuing in front of our goal—Mary's obtained the only point scored during the match. The rest of the game was of a rather uninteresting character and needs no description, Mary's continually attacking and being as continually brought up by our back division. As far as individual play was concerned, Hewitson and Crosby shewed to great advantage, and we have rarely seen them play better, while Cooper, although evidently suffering from the effects of his collision, was of great service to our side. In conclusion, we might remark that despite the efforts of the *five* Guy's spectators, the marked enthusiasm of the Mary's supporters contrasted strangely with the total lack of interest evidenced by Guy's men in the doings of their team.

We append the names of our team—N. Lavers (goal); A. B. Carter, F. J. Lidderdale (backs); H. Hewitson (captain), N. C. Cooper, A. E. Crosby (half-backs); F. E. Walker, B. F. Pendred, R. T. Fitz-Hugh, E. C. Davies, R. B. Stamford (forwards).

Rugby Football.

GUY'S HOSPITAL v. ROSSLYN PARK.

This, the return, was played at Acton, on January 27th, and a splendid game resulted in a victory for Guy's by two tries (six points) to one try (three points).

Jones won the toss, and the home team started the ball against a strong wind. It was soon seen that the game would be fast and open, both teams quickly adopting the heeling tactics. From a scrum in the centre of the field Jones got nicely away, and some pretty passing between Bell and Wetherell resulted in the latter being tackled close to our opponents' goal line. From the scrum which followed, the ball was kicked over the goal line, Reid saving. After the drop out the Guy's forwards had considerably the best of the play, and, heeling out, some smart passing between Jones, Mathias, and Bell gave the latter a good opening which he took advantage of, scoring in the extreme corner. The kick at goal by Shorland, although a good attempt, was not successful. After the kick-off the Rosslyn Park team played up with great dash, and, after an excellent round of passing and a good run by Sexton, Evershed scored a try which was not improved upon. Stoker dropped out, the ball being well returned, play settling in the Hospital twenty-five, and a free kick given against a Guy's forward for off side nearly resulted in a goal, Sexton making a brilliant attempt, Alexander touching down. Some give-and-take play followed, and nothing further was scored up to half time, the teams crossing over with the score one try each.

On re-starting, Mathias and Stoker came away down the touch line with a good dribble which nearly resulted in a try. Rosslyn Park now pressed and Chaldecott was well tackled by Dudgeon when looking dangerous. Some good passing between Jones and Mathias gave Wetherell a nice opening, and running through well he passed to Bell who, going at his fastest, easily raced round the Rosslyn Park back and scored rather far out, the kick at goal just failing. From now until the end of the game Rosslyn Park forwards had the best of the play, and once Chaldecott was grandly tackled by Slater when he appeared certain to score. No further point was obtained, and the game ended as above.

REMARKS.—It was at half-back we had the advantage, Jones and Mathias completely outclassing their opponents, the former especially playing brilliantly. Bell was in his best form, being far the best three-quarter on the ground. The forwards played splendidly, getting the ball in the scrums and heeling smartly, but a few of them lacked training. Slater was the pick, playing a grand game, and Stoker, Dudgeon and Rowlands showed up wonderfully well. Team:—

GUY'S.—K. B. Alexander (back); T. Wetherell, H. T. Bell, H. M. Stewart (three-quarter backs); M. P. Jones and R. Mathias (half-backs); F. O. Stoker, E. T. Shorland, R. S. Rowlands, L. Slater, E. D. Hancock, H. W. Dudgeon, C. R. Nicholson, W. Tyson and C. D. Edwards (forwards).

GUY'S 2ND XV. v. ROSSLYN PARK 2ND XV.

This match was played on Saturday, January 27th, at Honor Oak Park, and, after a grandly contested game, resulted in a victory for Guy's by a dropped goal and three tries (thirteen points) to nil. Goal by H. T. Hicks; tries by E. H. van Someren, V. E. Collins and H. Walling.

Appointments.

JACKSON, PHILIP, M.R.C.S., L.S.A., has been appointed Medical Officer to the South-Eastern District of the Post Office.

OLDHAM, C. J., L.R.C.P. Lond., F.R.C.S., has been appointed Honorary Surgeon to the Sussex Eye Hospital, Brighton.

UHTHOFF, J. C., M.D. Lond., M.R.C.P., F.R.C.S., has been appointed Honorary Surgeon to the Sussex Eye Hospital, Brighton.

Births.

GREENWAY.—On January 24th, at Dover, the wife of Surgeon-Captain J. H. Greenway, A.M.S., of a son, who survived his birth only a few hours.

HEARNDEN.—On January 15th, at Leatherhead, the wife of Walter C. Hearnden, M.R.C.S., of a son.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

FEBRUARY 24, 1894.

Inter-Hospital Cup Ties.

OUR "Leader" of a month ago not only provoked great comment within these walls, but has excited extramural controversy, as we find in the latest issues of the *Bart's.* and *St. George's* journals articles under this heading, and further correspondence is invited. The former strenuously supports the present system, and recapitulates the arguments set forth by "Rugger" in our last number, *e.g.*, the blocking out of present deserving students in Cup ties in favour of "crocks," and the diminished chance of new men obtaining a good football education, moreover the opinion is given that year by year fewer places would be vacant, and the ambitions of new players would thus receive less and less chance of gratification.

We are entirely with *St. George's* in regarding the present time limitation as anomalous, and we think their point, that "whilst it affects London men, it hardly touches those who hail from one of the Universities," is decidedly important. They regard—in opposition to "An Old Cap," who, by-the-bye, was rather severe on other "Old Caps" now about the Hospital—the abolition of the time limitation as favourable to the larger schools, on the ground that "they have more men to draw upon who at present are debarred from playing in Cup ties, and consequently play for other clubs." We think that the view of "Who-would-be-benefited-by-it" is of very little importance, and scarcely to be considered, as it appears to us to cut fairly equally both ways.

The *St. George's Gazette* here introduces an anomaly of its own production, for while in favour of the abolition of the time limit, it proposes that a rule be passed limiting the selection of players to those actually frequenting their hospitals, and that such a selection might be trusted to the honour of individual committees. We fail to see that "individual committees" have of late years even justified the small trust at present placed in them.

In any case *St. George's Gazette* suggests the limit, if maintained under the new regulations, should be a five years' one, and they, by-the-bye, would like to see the time of play altered from forty to thirty minutes each way, as they regard the longer period excessive, "if not actually dangerous," to men in ordinary hospital training. We think, however, that our contemporary could ascertain, on more minute inquiry, that Cup teams—certainly those from the larger and more prominent hospitals—are not allowed to be "in the training which any one who attends a hospital must be."

We hear that the *St. Thomas's Gazette* is also eloquent against the abolition of the time regulation, but a copy of the paper has not yet reached us.

We desire to state that our columns are still open to more opinions, which we are most anxious to have the pleasure of digesting, and that at some early date we shall again let loose the editorial pen on the subject.

Case of Cerebral Tumour.

CLINICAL LECTURE BY DR. HALE WHITE.

GENTLEMEN,—The case we will take for our lecture to-day is that of a little girl, aged nine, who was brought to the Eye department of the Hospital on December 8th, 1893, for blindness. There is nothing in the family history to lead us to suspect syphilis or tubercle, and the child herself has always had good health till the commencement of the present disease.

Three months ago the mother noticed that her daughter's eyesight was failing, and she thinks that for the last fortnight she has been quite blind. Two months ago, when coming out of school, she had a fit, which has been succeeded by others. After the fits she is sick, and complains of severe pain in the head. The fit begins with screaming, and the child puts her hand to her head on account of the severe pain there. All the limbs are thrown about, and the eyes are rolled. The movements soon cease, then she is quiet for a few minutes, and then she is sick as she begins to recover consciousness.

On admission.—She walked into the ward. She has no ataxy nor vertigo, but is obviously blind, and cannot even see the light of a lamp. She is very thin and pale. The abdomen is remarkably retracted. The heart and lungs appear normal. There is nothing abnormal in the urine. The sensation is normal; and although, perhaps, the legs are weak, there is no paralysis of any part of the body. The right knee-jerk cannot be obtained; the left is feeble. There is no ankle-clonus. Plantar reflexes are absent. Epigastric reflexes are present. The mental condition is variable. At times she is bright and cheerful, but she is generally quiet, and answers slowly and rather stupidly.

Eyes.—Both pupils are dilated, and neither reacts to light. Both discs are in a condition intermediate between neuritis and atrophy. The margin is a little indistinct, the disc is of a bluish white colour, and the arteries are small.

December 11th.—The child had a fit. No one saw it, but afterwards she was sick and cried because of the headache.

26th.—She has had several fits, in many of which there has been marked opisthotonos, and she is always sick and has much pain in the head after them. She also has headache apart from the fits. As the fits have gradually become more frequent, the mercury which she has had since admission has been omitted, and she has been given some bromide of potassium.

30th.—During the last ten days the child has become markedly worse. She is thinner, and complains of more headache, especially at night. The fits are more frequent, and there are often three a day. She has been carefully watched to see if they begin in one part more than another, but this cannot be made out.

Jan. 1st, 1894.—She is very drowsy, and cannot be got to feed herself, although she easily swallows when food is put into her mouth. The pulse has been frequently observed to be very slow—sometimes beating only forty to the minute. She has suffered much from constipation.

5th.—There have been no fits the last few days; she is drowsy and will not answer questions; the knee-jerk is present on the left side, but absent on the right. The wasting is very marked, and the abdomen is much retracted. The optic discs are much the same as on admission; the temperature is usually subnormal, often being as low as 96.

18th.—She has gradually become more drowsy, and, as she is now unable to swallow, she is fed with nutrient enemata. The temperature went up suddenly yesterday to 103·6, and is at the same point this morning. The emaciation and retraction of the abdomen are extreme, the anterior abdominal wall lying on the lumbar vertebræ.

19th.—In much the same condition. The temperature is still high.

21st.—She died this morning about 7.30 a.m. Half-an-hour previously the respirations were noticed to be failing, and the temperature rose to 106·4. Sister says she noticed that the pulse went on beating for some time after the respiration had stopped.

This, then, gentlemen, was the case, and we have to diagnose it, and so you and I will go over the points that will help us to do so. The child was sent to us from the Eye department, because, from the neuritis and atrophy of the discs, it was strongly suspected that she had a cerebral tumour, and therefore it is our duty to examine this diagnosis to see whether it is probably correct.

Now the symptoms of cerebral tumour are divisible into three groups. The first group contains the symptoms due to the mere presence of a foreign body within the cranial cavity; the second consists of symptoms due to the position of the tumour—localizing symptoms as they are called; and the third group contains those symptoms due to the particular variety of tumour that is present, a rapidly growing malignant tumour producing different symptoms from a slowly growing innocent tumour.

FIRST GROUP. These symptoms are caused by the great increase of the intracranial pressure. If the tumour is large and rapidly growing, it may of itself add considerably to the bulk of the cranial contents, but sometimes even very large tumours do not do this, because they destroy a sufficient amount of brain substance to compensate for their own bulk. Cerebral tumours, which either directly or indirectly impede the flow of blood through the veins of Galen, also lead to great increase of the intracranial pressure, because of the collection of fluid in, and consequent distension of, the lateral and third ventricles which ensues upon pressure on these veins.

This group of symptoms, due to increased intracranial pressure, contains the following:—

1. *Headache*, due to the increased pressure jambing the meninges against the bone, and thus pressure is exerted upon the branches of the fifth and other nerves which supply the meninges. This headache, which is rarely or never absent in cerebral tumours, is often at

first paroxysmal, but later on becomes constant. You will remember it was so in our patient at first. She had severe paroxysms of headache after the fits; later, the headache was continually with her. It is usually very severe, and often keeps the patient awake at night. Both these points were also sometimes exemplified by our case. Be especially careful in any case in which the headache keeps the patient awake at night, for then there is a very strong probability that it is not functional. The headache may be most intense over the tumour, but this is exceptional, usually it is diffuse, as in our patient, for the increased pressure is felt equally in all directions. The pain is more frequently localised over the tumour in cerebellar tumours than others, because the cavity of the skull below the tentorium is a little cavity by itself, and therefore especially feels any increase of pressure within it. Occasionally, when the tumour is near the surface of the brain, there may be a tender spot on the skull. An occasional mistake made about the headache of cerebral tumour is to conclude that because a patient has headache and difficulty of sight, a cerebral tumour is present, when in reality both the symptoms are due to hypermetropia. I have known this mistake made, which, however, shows great carelessness. Always be on the look out for reflex headaches. I have known a headache, thought to be cerebral, cured by the extraction of a tooth.

2. *Optic Neuritis.*—By far the commonest cause of optic neuritis is a cerebral tumour, the next most frequent is meningitis. So frequently is it found in cerebral tumours that if it is well marked, its presence should, if there are no signs of any other cause, always make us think of a cerebral tumour. I have, however, seen a case of primary optic neuritis which gave rise to the erroneous diagnosis of cerebral tumour, but primary neuritis is excessively rare. The size, locality, and nature of the tumour have no influence upon the degree or variety of the optic neuritis, the only fact in this connection that we know is, that if in a case of cerebral tumour the optic neuritis exists in one eye only it will probably be on the opposite side to the tumour. Occasionally cases are met with in which the presence of a cerebral tumour does not give rise to optic neuritis, still the very important fact to remember is that it is of immense value in coming to a diagnosis of cerebral tumour.

It is extremely important also to bear in mind that the degree of loss of vision bears no relationship to the degree of optic neuritis. There is at the present moment a woman in Miriam ward who can see very well, but her discs have already begun to atrophy. In certain quite exceptional cases the loss of sight may be quite sudden, but usually it supervenes gradually, as in the patient whose case we are discussing.

I am well aware that it is quite open to criticism for us to have included optic neuritis among the pressure symptoms, for some very eminent authorities, such as Dr. Hughlings Jackson, are strongly of opinion that it is not caused by increased intracranial pressure. Be that as it may, clinically it belongs to the groups we are discussing, for it is a symptom which, while indicative of the presence of a cerebral tumour, has no localizing value. It would take us too far afield to discuss all the theories that have been put forward to account for optic neuritis. It will suffice if we state that the view that it was due to the influence of the increased intracranial pressure on the cavernous sinus or ophthalmic vein was shewn to be wrong, because the anastomosis between the orbital and facial veins is so free that pressure on the cavernous sinus does not lead to distension of the orbital veins. In very many cases the cavity of the sheath of the optic nerve, which is continuous with the subdural space within the cranium, is found distended when optic neuritis is present. This distension is doubtless due to the increased intracranial pressure, and the optic neuritis has been ascribed to this distension. The objection to this view is that you may find extreme optic neuritis without any distension of the sheath of the optic nerve even if a large cerebral tumour exists. A case we had in the post-mortem room on Wednesday, in which, owing to the rupture of an aneurysm at the base of the brain, hæmorrhage had occurred in the subdural space shews, as you could see, the optic sheath distended with blood, and thus demonstrated the continuity of the two spaces. Another widely held view of the causation of the optic neuritis is that the tumour acts as an irritant foreign body, and causes an actual neuritis of the optic nerve within the cranial cavity, and this neuritis, by descending, causes the inflammation of the optic disc. One fact is quite certain, namely, that a descending neuritis in the optic nerve is often seen in microscopical sections when it would never have been suspected from the naked eye appearances. I have often found this myself in sections, and have many which shew it. On this view the tumour sets up a microscopic meningitis which implicates the optic nerve. This view explains those exceptional cases in which, with a cerebral tumour, the optic neuritis is present in one eye only. Perhaps the correct solution of the question is that sometimes the optic neuritis is due to increased pressure, and sometimes to a descending neuritis. Other theories are that of Hughlings Jackson, according to which optic neuritis is a reflex vaso motor phenomenon due to the irritation of the tumour; and that of Leber, and others, who believe that in cases of cerebral tumour the fluid in the sheath of the optic nerve contains some particularly irritating material.

There is nothing especial to tell you in connection with the atrophy which, in this case and most others, follows upon severe optic neuritis.

Mistakes in the diagnosis of the cause of optic atrophy can only be avoided by care in going into the whole of the case, and the causes of optic neuritis. I have known a case of supposed cerebral tumour turn out to be the optic neuritis of anæmia, and the patient was cured by iron. On the other hand, I have known the neuritis of tumour put down as due to anæmia.

3. *Vomiting.*—Next to headache and optic neuritis, vomiting is the most common symptom of cerebral

tumour. Often, if there are fits, as in our patient, it occurs in association with them. The characteristics of it are that it bears no relation to food; is usually unattended with nausea, and commonly the tongue is clean. It may be paroxysmal. All these points are exhibited by our present case. Although in the greater number of cases it is due to an increase of the intracranial pressure affecting the central vomiting mechanism, still, sometimes when the tumour is in the posterior fossa it is due to direct pressure on the medulla.

4. *Pulse.*—It is very characteristic of an intracranial lesion that the pulse should be slow. It fell to 40 in our patient. The cause is that the increased pressure affects the intracranial cardiac mechanism.

5. *Vertigo.*—This is a very common symptom of intracranial tumour. It may be due to the direct implication of the middle lobe of the cerebellum by the tumour, but usually is caused by the increased intracranial pressure.

6. *Convulsions.*—You must always pay the greatest possible attention to these, for if they invariably begin in the muscles of some definite part, say the thumb or the toes, and from there gradually spread in the course of a few seconds to adjacent muscles, and if this march, as it is called, is always the same, and especially if the whole convulsion does not march far, so that, say, only one limb is affected, it is of the greatest possible value in diagnosis, for such a convulsion indicates a lesion of the cortical motor area corresponding to the convulsed part. You will remember that last winter, by means of such "Jacksonian convulsions," always beginning in the hand, we successfully diagnosed a tumour of the arm area of the cortex, and Mr. Lane excised it. But when, as in our present patient, the convulsions are general, and do not always begin in the same part, they are of no diagnostic value, and are simply due to increased intracranial pressure.

7. *Intellectual symptoms.*—You will be hardly surprised to hear that increased intracranial pressure commonly dulls the intellect, as in the present case. Ultimately the patient became stupid, drowsy, and comatose.

8. *Enlargement of the head.*—If the patient is of such an age that the cranial bones have not joined, the increase of the intracranial pressure will separate them, just as they are separated in a case of hydrocephalus, and the head will distinctly enlarge, and the veins on it become prominent. In the present case the child was too old for this to occur, but we thought that the roof of each orbit was driven down a little, so that the upper eyelid became more vertical than it is normally, as it commonly does in hydrocephalus.

9. *Wasting.*—Patients with a cerebral tumour usually waste extremely. Our child was literally nothing but skin and bones. The cause of this is obscure; it certainly has no localizing value, and is probably due to the increased intracranial pressure modifying in some way the general nutrition.

10. *Retraction of the abdomen.*—This also is often met with in cases of cerebral tumour. In our patient the anterior abdominal wall lay on the bodies of the vertebræ. Partly, no doubt, this is due, as the post-mortem here showed, to a total loss of all intra-abdominal fat. But this is not the whole explanation, for it would not be so noticeable if the intestines contained their usual amount of gas. It is not of the slighest localizing value.

11. *Constipation.*—This, as in our case, is one of the general symptoms of a cerebral tumour. The cause is not known.

12. *Thinning of the bones of the skull.*—In some cases the increase of the intracranial pressure is so enormous that the bones of the skull become very thin and atrophied, and this you must remember occurs when the tumour does not anywhere come in contact with the skull, so that it is simply due to the increased intracranial pressure. The bones become very thin, light, and semi-transparent when held up to the light, which also, owing to their tenuity, shows their vessels as a most beautiful aborescent network. The thickness, in extreme cases, of the bones of the vertex is no greater than that of thin cardboard. The specimen I have here shews these points admirably. It was taken from a case of cerebral tumour. We have a specimen in the museum in which this thinning from increased intracranial tumour has actually laid open the tympanum. There is nothing noteworthy about the exterior of the skull, but the inner surface of the bone is roughened like sand-paper. Sometimes this thinning is so marked that it can be detected during life, for the thin bone can be pressed in, when it rebounds like the bottom of an oil can.

13. *The temperature.*—You know that sometimes this is of localizing value, the best known instance being the rise of temperature that you may find associated with a tumour of the pons. Apart, however, from this question, we occasionally notice that, as in the present case, shortly before death there is a great rise of temperature. In our patient it rose to 106·4. I know of cases in which it has risen to 107·4 and 108. Such an extreme rise is of great prognostic value, for it means that the end is near. It is of no localizing value, for it is probably due to the fact that the increased intracranial pressure has at last exhausted the cerebral thermic mechanism.

These general symptoms, gentlemen, are those which indicate the fact that your patient has a cerebral tumour, without helping you in the slightest to the position of it. I have given you them in the order of their importance and frequency. You will see that we were able from them easily to say that our patient had a cerebral tumour.

THE SECOND GROUP of symptoms indicate where the tumour is. They are the localizing symptoms, and owe their presence to the fact that the tumour locally destroys some part of the brain which has a local definite function. For example, if the patient had paralysis of the third nerve, we might conclude that there was a tumour at the base of the brain pressing on it. We had an instance last week, in which an intracranial aneurism pressed on the third nerve, and caused paralysis of it. If the tumour causes local fits in one

arm, as in the woman we had in a year ago, it means the tumour implicates the cortical arm area on the opposite side. If the tumour causes glosso-labio-laryngeal paralysis, it is somewhere about the medulla. If it causes ataxia, it implicates the middle lobe of the cerebellum. If it causes contracted pupils and crossed paralysis, it is in the pons. Now in our case the tumour caused absolutely no localizing symptoms. In what places therefore can a tumour be, and yet cause no localizing symptoms.

By far the two most frequent seats for it in such a case are either lateral lobe of the cerebellum or either frontal lobe. Lesions here are not known to have any localizing value. A tumour in the occipital lobe or in the path of visual impulses might conceivably, when there was optic atrophy, cause no localizing symptoms, for the presence of the atrophy would render it impossible to detect the amblyopia or hemiopia that should result. I shew you here a large tumour of the cerebellum which caused abosolutely no localizing symptoms, and I have met instances of tumours of the frontal lobe causing no localizing symptoms. Perhaps one of the most striking was a patient, the sister of the waiter at Dr. Moxon's club, who only complained of slight headache, and whom Dr. Moxon would not have taken into the hospital except to oblige her brother. Optic neuritis was found, and cerebral tumour was diagnosed. She was perfectly intelligent and could see well. Before admission, she had been arranging the furnishing of her house, as she was about to be married; when in the hospital, she helped the nurses in their work. One day she dropped down dead, and a large glioma was found in the left frontal lobe. The probable reason why tumours of the frontal and lateral cerebellar lobes cause no symptoms is, that these parts are concerned in intellectual operations, and therefore, their functions are less fixed in local parts than are the functions of other parts of the brain, for the intellectual functions have been later developed, both in the evolution of the species and the life of the individual, and it is well known that a long period of evolution and increasing age of the individual are both associated with a localization of function in definite parts. As the functions of the frontal and lateral cerebellar lobes are feebly fixed, when these parts are destroyed, neighbouring parts, or possibly the corresponding part of the opposite side of the brain, will probably be able to take on the functions of the destroyed parts.

The outcome of our diagnosis so far, is that our patient has a tumour of the brain in some part which does not give localizing symptoms; probably, therefore, in the lateral lobe of the cerebellum or the frontal lobe.

THE THIRD GROUP of symptoms we have to consider are those which indicate what the tumour is. Out of 100 consecutive cases of cerebral tumour that have occurred in the post-mortem theatre of this hospital, the growth was tubercular in 45, a glioma in 24, a sarcoma in 10, a carcinoma in 5, a glio-sarcoma in 2, a cyst in 4, a gumma in 5, a lymphoma in 1, a myxoma in 1, and doubtful in 3. There was in the present case no evidence of growth elsewhere in the body, so it was almost certain that the cerebral tumour was not a sarcoma or a carcinoma. We were last year able to diagnose a sarcoma of the brain from the fact that the patient had had one in her breast. There was no evidence of congenital syphilis in the present case, so a gumma was out of the question, and, therefore, we were narrowed down to a diagnosis between a tubercular tumour or a glioma, for the others are so rare. Now, of the above 45 cases of tubercle, 24—or more than half—were under ten years of age, but of the 24 gliomata only 2 were under ten years of age. So that out of 26 cases of tubercle and glioma under ten, only 2—that is to say, about eight per cent.—would be glioma, therefore there was a very strong probability that our patient, who was only nine, was suffering from a tubercular tumour. You learn from these figures the great probability that any cerebral tumour in children is tubercular. In this particular case the probabilty that the tumour was tubercular was enhanced by the fact that we had reason to believe it was in the cerebellum, for that is a very common seat for a tubercular tumour. The only reason against this view was that there was no evidence of tubercle elsewhere in the body, and this was strongly against the diagnosis, for tubercle of the brain is almost always associated with tubercle elsewhere, still the tubercular disease elsewhere often gives no symptoms.

Autopsy.—Now I shew you the brain you will see that our diagnosis was partly correct. There is a cerebral tumour growing from a part where it would give no symptoms, for it is a growth the size of a filbert nut, springing from the right optic nerve just anterior to the optic commissure, pressing on the left optic nerve, and growing upwards through the anterior perforated space into the third ventricle, where you see it bulging. The upper part of it is cystic. By its pressure backwards it had doubtless greatly impeded the flow through the veins of Galen, for both lateral ventricles were very distended, and the convolutions of the brain were flattened, thus explaining the pressure symptoms. There was no sign of meningitis. As the patient was blind when she came in, we could hardly be expected to diagnose a tumour in such a very rare position. The principle of our diagnosis was correct, namely, that the tumour was not producing localizing symptoms. It certainly is not tubercular; in all probability, histologically it will turn out to be a glioma. The figures I have quoted show how excessively rare such a tumour is at such an age. Perhaps we ought, considering the absence of signs of tubercle in other organs, to have been more chary of expecting the growth here to be tubercular.

Prognosis.—This, in all cases of cerebral tumour, is very grave, but probably certain rare cases recover. Here is a child who came into the hospital in 1885, and was under my care: she then had optic atrophy and headache—no localizing symptoms whatever. She has now recovered from her headache and is well, except that she is quite blind; she is very intelligent, and can play and sing. Probably her tumour is in the lateral lobe of the

cerebellum or the frontal lobe, is tubercular, and has become quiescent. I have seen one other case recover. In that case the tumour implicated the frontal lobe and it grew through the frontal bone. The opening was enlarged and the tumour was burnt away with nitric acid. The child made a complete recovery, and gained prizes at Board Schools. But these cases are so rare that they should hardly influence you in your prognosis.

Treatment.—What we have to say about this is really a part of the subject of prognosis. If there is a fair amount of evidence that the tumour may be a gumma, there is some hope, for you may absorb it by means of full treatment with iodide of potassium and perchloride of mercury, but, remember that only five per cent. of all tumours are gummata, and that by the time you get the case, it may have done irreparable and fatal damage to the brain, and that, even if you absorb it, the scar tissue left may cause serious symptoms. Some tumours may be cut out, but unfortunately, the great majority are either too difficult of exact localization, too diffuse, too large, out of reach, multiple, or associated with disease elsewhere in the body. Judging from my own experience, I should say that probably not ten per cent. of the cases are capable of being relieved by operation, although in proportion as the cases are recognized early, so will this percentage increase. If you decide that the case is not one for operation—and the one we are discussing certainly was not, as we could not localize it—you should either give cod-liver oil, if you think the growth tubercular, or else large doses of iodide of potassium and mercury, in the hope that it is syphilitic. I usually give the perchloride of mercury, an eighth of a grain in five minims of water, injected deep into the gluteal muscles once a day, and thirty grains of iodide of potassium thrice a day. These doses—which are those for an adult—get the patient under rapidly, and this is all important.

Mode of death.—Under this heading I wish to direct your attention to two strange facts. One is the number of cases of cerebral tumour which died suddenly. In fourteen out of thirty-one cases death was sudden. For instance, in one the nurse, in the middle of the night, lifted a patient with a cerebral tumour forward to give him something to drink; he fell back dead. A woman was standing peeling some potatoes; she dropped down dead. One patient was noticed to be all right; a few minutes after, when the nurse went to the bed, he was dead. Probably the reason of this sudden death is that some slight shifting of the head brings the increased pressure to especially bear on some vital part, probably the vagi. The other fact is, that often the pulse goes on for quite a long time, it may be half an hour, after the breathing has stopped. That was so in our present case, and I know of several others. No satisfactory explanation has, as far as I know, ever been given of this. Strange to say the patients do not turn livid, although the respiration stops completely. I never heard of a case in which the pulse stopped first, and the respiration went on.

Ætiology.—It is a well known fact that three males have tumours of the brain to one female. This has been stated to be because men are much more liable than women to blows on the head, for in some cases it appears that the tumour has developed after a severe blow. Our figures at Guy's, however, show that this is not the sole explanation, for male children are more liable to tumours of the brain than female chidren. The cause of this predisposition of the male sex is quite unknown.

Hospital News.

In the Surgical Wards.

Under Mr. Lane.

Job 22.—Hernia.—O. B., æt. 47. Admitted 13th February; died 14th February, 1.15 a.m. Patient was ruptured by a fall twenty years ago, has worn a truss, but swelling increased. On 11th patient felt sudden violent pain in the evening in hypogastric region, accompanied by vomiting of blood and inky fluid with fæcal odour, which continued till next day. Next day the blood ceased in the vomit but inky fluid continued till admission. Pain increased, and patient was brought to Hospital.

On admission.—Patient's scrotum was fifteen inches long and eighteen inches round, and reached nearly to internal condyle. The hernia was irreducible, but movable in scrotum and came down left inguinal canal.

Operation by Mr. Lane, under A.C.E., 5 p.m., oblique incision nine inches long, commencing two inches internal to ant. sup. spine, and crossing inguinal canal to scrotum. On opening peritoneal cavity, the stomach presented and was found to prevent any return of the intestines to the abdomen. There was no strangulation. A tube was passed into the stomach but no fluid or air could be drawn off. The wound was then stitched and dressed. I.M.H. $\frac{1}{6}$ gr. administered. Patient never regained consciousness and died at 1.15 a.m.

Autopsy.—The sac contained nearly all the small intestine, the cæcum and all large intestine to sigmoid. No strangulation at neck of sac. The omentum was adherent at bottom of sac. Liver 54 ozs., fatty; heart 15 ozs.; kidneys 14 ozs., cystic; spleen 5 ozs. The stomach contained several small ulcers two inches from pylorus.

Job 22.—Strangulated Hernia.—J.R., æt. 36. Admitted 13th February. Patient was ruptured lifting a bag of biscuits in Zululand, in 1879, wore a truss till it broke, and then did not get another. Tumour has come down several times but patient has reduced it. On the 13th it came down and patient could not reduce it.

On admission.—Scrotum was five inches long, tumour coming down right canal. Patient has vomited a good deal. There is still an impulse on coughing. Hernia had been down an hour, and patient was in great pain.

Operation by Mr. Sharp, under A.C.E. Tumour had increased to eight or nine inches long. Incision over

line of canal and inner ring was enlarged, the gut, about four inches or five inches long, was got back with some difficulty. The wound was stitched with deep gut and superficial horsehair sutures. Dressed and bandaged.

16th. Deep stitches taken out and re-dressed.

20th. Dressed again. Quite healthy.

Temperature:

Feb. 15th.	4-hour chart,	10 o'clock	98	6 o'clock	100·2
" 16th.	"	"	99·6	"	99
" 17th.	"	"	99	"	100
" 18th.			100·4		
" 19th.	"	"	99·4	"	100·8
" 20th.			99		

In the Medical Wards.

UNDER DR. PYE-SMITH.

PHILIP 30.—G. J. S., æt. 39. Admitted December 12th, 1893. A brother died of "consumption," and a sister is attending Brompton Hospital. Parents are both alive and well.

Three months ago he began to have pain in the stomach, coming on about half-an-hour after food. He has vomited once; has suffered much from constipation; and he has lost two stone in weight.

Anæmic, with a yellowish tinge; tinea versicular over chest and shoulders. A hard mass, about two and a half by one and a half, was felt just above and to the right of the umbilicus, and there were the signs of the dilated stomach. The heart was normal. At back of apices of lungs there was impaired resonance, and râles were heard here.

His bowels were kept open, and he went out on January 14th, 1894, with the pain and constipation somewhat relieved. On discharge there were râles over the front of left apex.

Re-admitted on February 7th for the pain, vomiting and wasting. The tumour is more distinctly felt, extends across the middle line just above the umbilicus, being about three by two inches. The apices of lungs give the same physical signs as on discharge, and there are râles in the fifth right space outside the nipple. He has pain, and vomiting of food, but not of blood.

PHILIP 27.—G. D., æt. 53. Admitted for œdema of legs, dypsnœa, and cyanosis. He has been in three times before for exactly the same condition. Patient is very fat, and his lungs are emphysematous. The heart is normal. The urine contains a trace of albumin, and there are hyaline and granular casts in it. Chronic bronchitis and emphysema, with dilated right heart (though no murmur is made out), is the cause of the present attack. Dr. Pye-Smith thinks there is independent nephritis, in the shape of a granular kidney, and that the albuminuria is due to this, and not to the backward pressure from the heart, for the presence of casts is against this latter explanation.

MARY 37.—P. V., æt. 16, domestic servant. For three months has had pain in chest, breathlessness on exercise, buzzing in ears, spots before the eyes, loss of appetite and general weakness, constipation, and amenorrhœa.

She is anæmic, but with no well-marked greenish tint. The heart's impulse is only slightly displaced; there is a systolic pulmonary bruit, and a venous hum in the neck. Respiratory system is normal. Urine normal. The temperature is not raised at all. The blood has not yet been investigated. There is no history of rheumatism.

Diagnosis.—Chlorosis.

Treatment.—Pil. Ferri. iij. t.d.s., Mist. Rosæ. Laxativ. ʒi. bis die. Beef tea with two eggs and farinaceous. To stay in bed.

MARY 35.—Anorexia Nervosa.—E. V., æt. 19; no occupation and unmarried. No previous illness. For the last three years, following a fright, she has had headache, pain in chest, abdomen and legs, which is not at all localised. She has no appetite, refusing food; but there has been no vomiting. She has constipation. Menses regular till last October when they ceased. The circulatory, respiratory and urinary systems are normal, and no lesion can be found at all. She cannot taste her medicine which contains valerian.

Treatment.—To stay in bed. Milk ʒij. 2 hours. Gr. Nux. Vom. ɱx., Sod. Bicarb. gr. x., Inf. Valerian ad. ʒi., t.d.s.; Pil. Aloes et Myrrh a.o.n.

February 17th. Bread and milk puddings, beef tea.

19th. As she complained of not sleeping at all, Dr. Pye-Smith gave her Camphor gr. i., Extr. Hyoscyami gr. iij., ft. pills p.r.n., on the principle that imaginary ills could be treated by what was to her medicine for them.

UNDER DR. TAYLOR.

MARY 40.—L. P., æt. 19. Admitted February 13th, with anæmia, dyspnœa, pain in chest after food. Patient is a kitchen-maid, standing a good deal.

Family history.—An aunt and a cousin died of consumption.

Personal medical history.—Measles when a child; has always been subject to frontal headaches, and of late to constipation and indigestion, especially the last nine months. *Present disease: Nine months ago had* pain in front of chest, also weakness, with fainting fits. Later on, dyspnœa and palpitation, especially after walking. Periods regular, but have been diminishing in quantity lately.

Condition on admission.—Patient appears well nourished, but skin is anæmic, with flush on cheeks.

Circulatory system.—Impulse in fifth space, just external to nipple; cardiac dulness normal; apical systolic bruit, traceable into axilla and over sternum; no bruit de diable; pulse weak; blood corpuscles normal in quantity; hæmoglobin 35 per cent.

Alimental system.—Lips and gums are pale; appetite is poor; nausea and erructations present; bowels are very constipated.

Respiratory system.—Normal.

Treatment.—Mist. Ferri et Quassiæ, ʒi. t.d.s. Pil. Aloes et Ferri, gr. v. t.d.s.

UNDER DR. HALE WHITE.

MARY 3.—K. E., æt. 31. Admitted February 12th, for pains in feet and palpitation. Had rheumatic fever eight years ago.

Present illness.—Four months ago noticed pain in ankles and palpitation on movement; latterly palpitation when quiet. Has been quite unable to walk since illness commenced. Cannot feel the ground when she stands up; feels as if "standing on air." Two months ago could not hold knife and fork, had to use both hands in lifting a tumbler from the table—this symptom has disappeared lately. No history of alcoholism.

On admission.—Nervous System. Reflexes.—Knee-jerks and plantar reflex absent. No ankle clonus.

Motor.—She has drop feet. Unable to flex ankle. Grip of both hands fairly good.

Sensory.—Small area below each inner malleolus insensible to touch, also anæsthesia of plantar surface of right foot. She can feel, but over ankles and legs cannot distinguish between a pin prick and a touch. Tickling the soles of the feet gives her a burning sensation. Has shooting pains up the legs when ankles are flexed. Can distinguish between hot and cold. Pressure on webs between toes caused pain.

Trophic.—Wasting of legs. Calves of legs used to be much stouter.

Circulatory system.—Impulse sharp and short in character. Faint systolic bruit at apex.

STEPHEN 27.—T. G., æt. 24. Admitted January 10th, for weakness and vomiting of blood. Father died of consumption. Has been very healthy up to the time of present trouble. He was in the Navy, and has been abroad—West Indies, North America, Spain and Egypt successively.

Present trouble.—Last July had pain in epigastric and right hypochondriac regions. Treated for enlargement of liver in Suez. Vomited a good deal, but no blood. Last September began to bring up blood; noticed his motions dark. Treated for gastric ulcer since October last, without much benefit. During this time has vomited frequently, but only twice has there been any blood.

On admission.—Is very anæmic, with slight yellow tinge.

Alimentary system.—Tongue pale and furred; bowels fairly regular; abdominal wall normal.

Circulatory system.—Systolic bruit over base of heart, fourth space. Bruit de diable present. Pulse 100; dicrotic, weak.

Blood.—Corpuscles, 57 per cent.; hæmoglobin, 40 per cent.

January 22nd. While eating his dinner had an attack of vomiting, with severe pain in epigastrium; pulse was very rapid and thin, cold perspiration over face. Vomit consisted of curdled milk, no blood present.

23rd. Patient again vomited last night, although milk was reduced to ʒij.; no blood.

24th. Patient is sick.

February 5th. Feeling of sickness; diet farinaceous.

9th. Vomited blood and food; diet milk.

12th. Resistant mass felt at right end of epigastric region; dull on percussion.

16th. Swelling has disappeared; last night patient passed about a pint of bright red blood per rectum. Noticed feeling of fulness in epigastrium disappearing. He also vomited half-a-pint of coffee-ground stuff, which did not give the reaction with phloroglucin and vanillin.

Remarks by Dr. Hale White: There is strong evidence in favour of the ulcer being duodenal. We note (1) its non-amenability to treatment; (2) passages of bright red blood per rectum, whereas the appearance of matter vomited about the same time is coffee-ground; (3) the appearance of a resistant mass at right side of epigastric region, and its rather sudden disappearance, this possibly was a clot of blood in duodenum—Dr. Hale White has seen a similar symptom in case of duodenal ulcer; (4) pain experienced by patient during his attacks is situated a good deal to the right.

Against duodenal ulcer is its rarity.

It is important in this case to correctly diagnose before giving a prognosis, since prognosis in gastric is more favourable than in duodenal ulcer.

A Case Treated with Sulphur.

F. L., æt. 30, was admitted into Accident, under Mr. Lane, with a severely lacerated forearm. He was cleaning a window at a height of forty feet, when the lower end of the ladder, on which he was standing, slipped, and the ladder broke in the middle where it was spliced. He fell, and his left forearm caught on some iron railings, one of the spikes of which entered his arm just below the inner condyle, so that he was left hanging by it. Patient was taken up to the theatre at once and anæsthetised. There was a large lacerated wound along the inner side of the left forearm, extending from one and a half inches below the internal condyle to a point two inches above the pisiform bone. The inner part of the belly of the flexor carpi ulnaris was smashed up and hanging from the wound. This was snipped off with scissors. There was a deep hole, into which the spike had gone, driving before it a piece of dirty coat, extending between the superficial and deep flexors in a direction downwards and outwards, nearly to the radial edge of the forearm. There was a good deal of general oozing, but the ulnar artery was uninjured, as was also the nerve. The wound was so severe and so dirty, that the question of immediate amputation was raised. However, Mr. Lane determined to try the effect of sulphur. The whole arm was thoroughly washed up, and the wound carefully gone over with 1 in 20 carbolic, and then packed with strips of iodoform gauze, which

had been wrung out of 1-in-20 carbolic, and then soaked in a mixture of sterilized sulphur and boiled glycerine, and dressed with bicyanide gauze and salicylic wool, an internal angular splint being applied. Patient complained of pain in the evening, but one-sixth of a grain of morphia gave him a good night's sleep. After twenty-four hours, the arm was dressed, the whole surface of the wound was of a dark greyish brown colour, smelt strongly of H_2S, but was otherwise quite sweet. It was syringed out well with Hyd. Perchlor. 1 in 2,000, and packed with iodoform gauze wrung out in 1-in-20 carbolic, and dressed again as before. For the next three days it was dressed daily, and since then every other day. The superficial black sloughs separated gradually and have now all come away, leaving a perfectly healthy granulating surface. The wound has been perfectly sweet all along, and patient has had no bad symptoms; the highest temperature recorded being 100·6 on the evening of the 11th. There can be little doubt that the sulphur, by destroying all the septic material which had been introduced by the dirty coat and iron spike, saved the man's arm, as in spite of the most thorough cleaning with carbolic it must almost certainly have otherwise become foul.

F. J. S.

A Case Illustrating the use of Artificial Inflation of the Lungs in New-born Children.

On October 21st, 1891, I delivered a primipara, of a full-time male child, presenting by the vertex, about three hours after complete dilatation of the os uteri. The forceps had not been applied. On being born, the child appeared motionless and dead; its limbs were in a condition of extreme flaccidity, and its skin of cadaverous appearance; there was no accumulation of mucus in or about the larynx. A slight attempt at gasping led to endeavours being made by artificial respiration, hot and cold suffusion, application of ammonia to the nostrils, and the rubbing of brandy upon the chest; but these had but little or no effect in restoring animation. A small quantity of dark venous blood was allowed to escape from the cut surface of the cord. An interrupted currency, both primary and secondary, applied to the neck and over the diaphragm, did not improve matters. The conjunctiva was insensitive to touch.

These remedies were adopted for fully half-an-hour, and were continued so long as there were several slight attempts at respiration, similar to those observed immediately after the birth of the child. There had not, up to this time, been the slightest movement of the limbs, and the case looked extremely hopeless. Remembering a suggestion thrown out by Playfair, I then decided to pass a large-sized catheter into the larynx and through it to inflate the lungs of the infant. With but little difficulty this was accomplished, and after several times inflating through the tube, the ribs were seen to be moving gradually more and more, till sufficient air was expelled through my catheter to extinguish the light of a candle held near its extremity. Finding that the natural efforts at respiration were becoming satisfactory, I removed the catheter, and was gratified by hearing a distinct cry and also by seeing some movement of the infant's extremities.

The child subsequently progressed perfectly well, and when I last heard of it, in January, 1894, was strong and hearty.

GEORGE H. RODMAN, M.D.

East Sheen, S.W.

A Case of Trismus Nænatorum.

I was called, on the evening of January 14th, 1894, to see the infant male child of a patient who had been naturally delivered seven days before.

The midwife in attendance had that day noticed that the child would not suck, and that its lower jaw was "fixed." She also gave a history that the child had "changed colour," becoming dark around the mouth at intervals during the day. There was no history of a definite fit of convulsions.

I found the child with some rigidity of the limbs, and with the lower jaw fixed tightly and slightly separated from the upper. It was so tightly contracted that it could not be opened with the finger, the tip of which could just be inserted in the space between the gums. The masseters were firmly contracted. The navel was perfectly normal in appearance. I ordered warm baths and the following mixture:—℞ Chloral Hydrar. gr. xii., Pot. Bromid. gr. xx., Syr. Prun. Virgin, ʒiss. Aq. ad. ʒiss. 4ts. horis.

The next day I again saw the patient, and then learnt that he had been convulsed during the night. There was more rigidity of the limbs, but episthotonos. The jaw remained in the condition described above. A pemphagoid eruption of the size of a pea had developed immediately round the navel during the fifteen hours since my first visit.

The child died early the following morning, and I learnt that the convulsions had become more frequent and severe towards the end, and that the jaws had become completely closed. The power of swallowing had been lost during the last twenty-four hours. The child's temperature was never above normal.

GEORGE H. RODMAN, M.D.

East Sheen, S.W.

Appointment.

Lee, Charles George, M.R.C.S. Eng., has been appointed Honorary Aural Surgeon to the Royal Southern Hospital, Liverpool.

The Ordeal for the Diploma in Public Health.

THE following is an account of the recent examination for the Diploma in Public Health, which we extract from a letter sent us by one of the successful candidates—an old Guy's man.

"We (*i.e.* twenty-three candidates) had, last Monday, two papers of three hours each. One of the questions in the second paper was a rather peculiar one.

"On Wednesday, we were sent, under sealed orders, to Charing Cross Railway Station, at 9 a.m., and there we saw several "conjoint" clerks, but we failed to elicit any information as to where we were going. At 9.15 a.m. Sir G. Buchanan, Dr. Seaton and "another" turned up; tickets were provided for us and we all went together like geese to the train for Caterham. We caused no end of audible comments from the crowd, some taking us for a funeral party, others for school-board inspectors, undertakers on strike, and so on. At Caterham we had a cruel walk through the rain and snow, and eventually arrived at the asylum. I tried to raise a chorus to the refrain of "For he's in an asylum now" but it fell flat, the miserable weather and the environments generally having apparently dispelled all ideas of humour. After having been numbered off to smell at soil pipes and crawl into sewers, etc., for two hours, we had one hour given us to write a report.

"Dr. Elliott, the hospitable and genial medical superintendent of the asylum, gave us a splendid lunch, and this did much to put us in our usual good humour with the world at large, and after thanking the matron and the good old doctor, we crawled off again towards the station, calling at most of the hotels on the way, for the purpose of analysing the spirits by the taste test.

"There was much speculation as to who the 'third party' with the two examiners was. Eventually we found out that he was an 'Examination Inspector' appointed by the General Medical Council to report as to the standard of examinations, there having been complaints that the examinations were 'too easy.' I don't know who made the complaints—I know I didn't. The examinations were much too hard for me and I was sent back twice on former occasions. On Thursday I presented myself for *vivâ voce* examination. I was No. 2, and on entering met No. 1, coming out with a face as long as a ladder, which to me was more significant than many words. The examiners were sitting one on each side of a square table, and the Inspector (Dr. Duffey, of Dublin, as I have since learnt) at another side, writing vigorously. I was, after having bowed my best, invited to take the vacant chair—which was a most comfortable one, in fact, too comfortable under the circumstances for real comfort. I should have preferred a good old cane-bottomed chair or a three-legged stool.

"Sir George opened fire on me, the painful pauses which occasionally occurred between question and answer being filled in by the Inspector's stylograph pen. Possibly the Inspector, who is no doubt an eminent sanitarian, was rapidly writing down the correct answers.

"Dr. Seaton then rapidly took up the attack, and after I had received their individual onslaughts for half-an-hour, I was told I could go; and, after again bowing and running into No. 3, who was vacantly staring into space, I left the room, and was told to go into the office to hear the result of my examination. Presently, I was told that I had passed, and I was asked to sign a diploma which states that after 'deliberate examination' I have been found well suited for smelling out fæcal and other nuisances.

"On Friday morning, having nothing else to do, I wended my way to the office of the General Medical Council to register my newly-acquired diploma. I took with me two half-crowns (nearly the last of the family plate), five shillings being the sum for registering other qualifications after the original £5 5s. registration. I was told that if I had come three weeks earlier I could have registered for five shillings, but that now I must pay £2 for that luxury. On asking for some explanation, I was informed that the General Medical Council had found it necessary to appoint an Inspector, and that the increase in the registration fee had been made in order to pay his salary.

"I consider this the coolest bit of business I have ever heard. If the General Medical Council think their examiners want watching, what has that to do with the poor devils of candidates, and why, in the name of conscience, should they be made to pay the piper; it is most iniquitous. I did not register, but I suppose I shall have to do so—when the diploma is likely to be of any service."

A. B.

Pass List, January, 1894.

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D. P. H. EXAMINATION.

Alfred Bolton, L.R.C.P., M.R.C.S.

Passim.

We regret that, owing to excess of Football news, which, of course, requires immediate insertion, we are compelled to hold over until our next issue the conclusion of the late Dr. Moxon's Paper.

In our last issue we gave a full account of the Association XI.'s defeat by St. Mary's, and deplored the fact in this column. However, it was afterwards found out that Mary's had unintentionally played a man who was ineligible —or rather, he was only ineligible in the spirit of the law, which states that "a man may only play for five seasons after registration," and makes no comments on the case of a man who enters a hospital previous to registration, which, we understand, are quite separate processes. In the case in point, E. G. Moon, Mary's left full back, had played for two years previous to registration. We, of course, after our defeat declined to take up the point, which was clearly unpremeditated; but Bart's. called the United Hospitals' Committee together, and in a somewhat stormy meeting attempted to decide that Mary's should play them in the second round without the man objected to. The Mary's representatives, who in the most sportsmanlike and amicable manner had agreed to withdraw Moon, though they easily might have protested —as the letter of the law did not touch their actions—here, however, objected that, though the letter of the law was silent on such points, clearly the spirit of the law demanded that, as Moon had helped them to defeat us, the match should be re-played, and such a course—notwithstanding the opposition of Bart's. — was eventually decided upon, with a very gratifying result to us.

The whole affair is simply an instance of the laxity and obscurity of the rules governing these contests, and merely a parallel of the Rugby Cup squabble of 1891-2.

With St. Mary's we must especially condole for the disastrous result (to them) of their noble and sportsmanlike action—an action we feel others might not have had the good feeling to perform, and we hope that it may ever be remembered by Guyites as a bond connecting them with the Paddington Students.

To-day at Walton—as flaring posters announce—the Association XI. do battle against Weybridge, in the presence of, we hope, a goodly crowd of supporters. We cannot help thinking that the difference of the displays given by the team in the two St. Mary's contests was in some measure due to variation—70 to 5—in the number of those cheering them on to victory, and another such crowd might kindle our not too brilliant chances into the flame of victory.

A. M. Daniel will again appear in the team to-day, taking Hewetson's place at half-back, the latter, with great self-denial — after his brilliant performance on Wednesday week—joining Stamford on the left wing. Those who have never seen this sterling half-back play, should seize this opportunity of doing so, as this is his last year of Hospital Ties. If any further inducement is necessary to bring men to Walton, it will suffice to mention that J. G. Veitch and G. H. Cotterill, both Internationals —the latter a brother of L. Cotterill, who was amongst the teams of 1890–91 and 1891–92—are included in the Weybridge ranks.

The Rugby Cup Tie v. St. Thomas's, which was postponed last Tuesday owing to the frost, will take place at Richmond on Tuesday next. Kick-off at 3 p.m.

The Association Cup Tie, v. St. Bart's., will be played on Thursday next, when operations will be started at 2.30 p.m. sharp.

IN the Cross Country Run which took place on Tuesday (13th instant) at Oxford, between teams representing Oxford University and the United Hospitals, Guy's had the honour of possessing the first three men home of the United Hospitals team, for H. A. Munro, C. D. Edwards, and P. F. Henry were placed first, fourth, and tenth respectively. The University were, however, easy victors, notwithstanding our good form.

THE opinions of misogynists and those who disagree with the place women are taking in the profession must have received rather a shock at the Ladies' night of the Debating Society, when for the second time we were honoured by the presence of students from the London School of Medicine for Women. It could be seen that concentration in study and hard work in chemical and other laboratories had in no measure lessened that feminine care of personal charm which we all prize.

ONE of the lady visitors was sufficiently interested in the debate to forget her umbrella. It is being guarded by the Secretaries of the Debating Society.

THERE will be a Smoking Concert to-night, held in the Smoking Room, at 8 p.m.

WE heard a tale the other day which helps to give some idea of the hazy opinions held by outsiders of things taking place within a hospital's walls. An old bachelor was moving his home, and to the enquiry of a lady friend he answered that he had taken a house overlooking the hospital garden at X—— (where, by-the-bye, there is no medical school). "Oh," said the fair questioner, "I wonder you could go there. I shouldn't have thought you would have cared to hear the shrieks and cries *from the Dissecting Room.*"

Guy's Hospital Debating Society.

LADIES' EVENING, FEBRUARY 10TH.

This was a noteworthy occasion; remarkable both as a success, and as a failure.

The Society was so fortunate in its guests that the evening must, on the one hand, be pronounced a great success; but, on the other hand, it was so far unfortunate in the attendance—and performances—of Guy's men, that it must also be called a failure.

Some sixty ladies were present, a large majority being Medical Students. To welcome them about thirty members of the Society turned up, and a scattered remnant of men who blocked the doorways with an air of languid curiosity. However, it cannot be denied that the debate was very enjoyable.

Perhaps the subject chosen for the debate was not one to make the members very anxious to attend; but had they known how interesting the ladies would manage to make it, they would not have hesitated.

"It is the duty of the medical man to endeavour, in all cases, to prolong life." This was the orthodox proposition maintained by Mr. BRICKDALE and negatived by Mr. HOPKINS. The opening speeches were both very moderate in tone; the first speaker relying for the most part on the argument that his position was essential from the point of view of the jurist, and the second limiting his remarks to the case of patients *in extremis*, whose remnant of life he held to be better left in peace. His arguments were directed solely against the strychnine syringe and such like temporary stimulation of hopeless cases.

Miss CAINE followed, supporting the opposition in a very able manner. We all felt sure, after she had broken the ice, that we should hear more from the ladies, and that the success of the debate was assured. Mr. Brickdale had drawn on the classics pretty considerably in his opening, and our first lady speaker remarked, pointedly, "I cannot quote Latin, as did the gentleman who opened, but perhaps I may quote Erichson"—which she did with good effect.

Mr. PAKES was for the opposition, and with some vigour supported the ethics of suicide, and justified the annihilation of monsters.

It was around these two points that the debate tended to revolve, in spite of the narrower limits set by the openers.

The following ladies contributed to the discussion, the opinions of the speakers being fairly evenly divided:—Miss Caine, Miss Micheson, Miss Hull, Miss Douie, Miss Orange, Miss Kaye, Miss Hughes, and Miss Wells. Of members, the following spoke:—Messrs. Campbell-Jenkins, Moon, Carpenter, Anderson, C. H. Fagge, Spon, Parry and Higgens.

An official division was first taken, limited to members. This showed a majority for the orthodox position in the ratio of fifteen to nine. Afterwards an informal vote of

everybody present gave orthodoxy sixty-three against forty-eight for the opposition.

One could not but feel at the close of the debate, that the ladies had merited the palm for eloquence, and perhaps for logic too. Apart from this some of our Philistines were a little surprised. They might have been seen staring through the windows from the quad, hoping to get entertainment from the view of a lot of bluestockings. When they saw the reality, they went away thoughtful. If it will not be thought impertinence, we should like to say, that one very pleasant aspect of the occasion to Guy's men was the direct proof it afforded that our lady colleagues can cultivate their intellects without the least abatement of feminine taste and charms. This is no mere compliment penned because the ladies were our guests, but really an echo of all we heard at the time. To be honest, the sentiment of delight was in some quarters mingled with that of surprise. So much for superstitions!

Dr. Pavy was in the chair, and presided with all his usual geniality.

Two Guy's Surgeons.

In the *Medical Magazine* for January, appears a most flattering review of the articles by Messrs. Jacobson and Lucas, on John Hilton and Edward Cock, in the Guy's Hospital Reports for 1892.

"G. J. W." expresses his delight in reading biographies of two such practical and clinical surgeons, and opines that it is wrongfully "too much the fashion among the younger generation of professional men to associate eminence in surgery with some new method of procedure, or some brilliant achievement in the way of an operation never hitherto thought possible. Rather," he says, "do those really leave their mark on surgery who, as clinical observers, have the acumen to perceive, the industry to collect and record, the intellect to reason from and compare the ever-changing phases of disease as they modify and are modified by the ever-varying individuality of the patient."

After touching upon the special qualifications of the biographers for such work, individual points are dwelt upon. Hilton's connection with Joseph Towne in the construction of our excellent wax models is made a special point of, but we cannot find any mention of his marvellous powers of giving to dry anatomical facts the juiciness and flavour of a teleological standpoint or a clinical observation.

Of course, "Anatomical" John's brusqueness and stern exterior have not escaped comment, but to us the picture has always appeared overpainted in the case of this man——a bachelor too,—who, when allowing just before his death to his old house-surgeon that he had been down on the men, but only for their good, having received the cheering reply that the house-surgeon thought there was not one of his old dressers who didn't think of him at least once a day exclaimed, "Do you think so, upon your honour?"

Mr. Lucas's task in writing an account of Edward Cock's life and doings is most favourably commented on; and the penalties Mr. Cock paid owing to his ever-ready humour, enhanced by his conversational turn and well-known stammer, are given due prominence. The strong points in "Teddy" Cock's character are amply denoted—his sound common sense and his great love for all students connected with him in any sphere.

Mr. Lucas's account of Cock's operation receives high praise, as does his lucid and able way of pointing out its uses and limitations; and Mr. Golding-Bird's paper on Urethral Surgery is instanced as exemplifying the value of the operation in suitable cases.

Students of Heredity are advised to digest the remark of Mr. Lucas, that "Cock, like his distinguished uncle, died childless," which is followed by other instances of the same fact.

F.

"A Soldier's Last Campaign."

I think the following account of the last hours of a soldier may be of interest, as shewing the wonderful reasoning power of an active brain, even in the face of impending death; the soldier's martial instincts rising to the fore; requests and commands being given in a perfectly clear and lucid manner.

A restless night had been passed, during which the patient's condition varied very much. The breathing was bad through the earlier hours of the night, but improved somewhat towards early morning. Unfortunately the improvement was only temporary, for at seven a.m. a dypsnœic paroxysm occurred. It was then that the battle (for I think it worthy of the term) began, the watchword being—*more air*. I should have mentioned that oxygen had been tried, but with no beneficial result. So the expedient of fanning was tried—partly at the nurse's suggestion, but also at the patient's own request. At first only one fan was used. This was continued till half-past eight, when another dyspnœic paroxysm came on, and the patient again had to be raised in bed. He then asked for more fanning, and also said,—

"I should like to have one window opened."

This was done, and his colour improved, as did also the breathing. There were now five fans at work. The patient a little later gave orders to decrease the number of fans, and said,—

"Stop fanning, two of you—three are enough with a window open; and when I shut my mouth, fan hard, for one side of my nose is closed up: when I open my mouth, fan gently, for then air can get in by my mouth and my nose also."

Somewhat later he said,—

"The doctors don't understand. They give oxygen, but I like *this* oxygen."

Commands were then given out with some rapidity, such as,—

"Fan hard, T——. Stop fanning, E——. Two fans enough when my mouth is open."

We continued like this for some hours. The patient then wanting to get some sleep gave directions of how the fanning was to be continued while he was trying to sleep. He said,—

"Watch my mouth, and when I open, fan softly; if I close, fan hard. Leave one window open until I am asleep."

We followed the directions implicitly, and in this way got him some hours' sleep. When he was asleep we left off the fanning. He slept till three o'clock in the afternoon, when he had another paroxysm of dyspnœa, which woke him up. Some time later he half lost consciousness. I pass over the remaining hours of his life, as what took place during them resembled what occurs in any case of slow asphyxia.

I have written this because it seemed to me a remarkable thing that one who knew that he was dying should be able to direct a plan for imbibing an extra amount of air, in order that he might live long enough to see a son once more before he died. It is difficult by words to describe the scene as it actually took place, but I think I have said sufficient to give some idea of what took place. I should add that the fanning was kept up continuously from half-past eight in the morning to three in the afternoon, that is for six and a half hours, and also that it seemed to improve his condition—unfortunately, only temporarily. Possibly some who read this may find this treatment beneficial in some cases of slow asphyxia which come under their notice. W. A. C.

From the Gazette's Special Pathologist.

W. H., Wanstead.—No tubercle bacilli were found, even after dissolving the pus. No crystals or blood present. There were a number of epithelial cells; a few of which were "tailed."

T., Queensgate.—No tubercle bacilli recognised.

R. A. M., Northampton.—A section shewed the growth to be an epithelioma growing from the nail matrix.

G. F. H., Balham. — The membrane consists of laminated swollen fibrin. No micro-organisms were apparent, but a microscopical examination could not be made. Tubercle bacilli were found in the sputum labelled "Gothard." The two others were free.

E. L. A., Tonbridge Wells.—Tubercle bacilli very numerous.

A. S. T., Surbiton.—No tubercle bacilli detected.

W. H. M., Kidderminster. — The arteries in the omentum are collapsed, while the veins and capillaries are dilated and congested. The veins are thrombosed but recently. There is well-marked diapedesis of leucocytes, and organisation is just commencing. Leucocytes, fibroplasts and red blood corpuscles fill the lymph spaces.

PATHOLOGIST.

Specimens for examination and description in this column, should be addressed to H. Hunt, Gazette, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

Odontological Society of Great Britain.

This Society was instituted in 1856 for the encouragement and diffusion of knowledge in Dental Surgery, and for the promotion of intercourse among members of the Dental profession. The society possesses a valuable museum and library at 40, Leicester Square, W.C., and the meetings are held at this address on the first Monday of each month, from November to June inclusive, for the reading of papers by members and others.

The Council has recently decided to admit visitors into the museum on Mondays, Wednesdays and Fridays, from 6.30 to 8.30 p.m., upon the presentation of a card of introduction from a member. It has also granted to visitors the privilege of using the library on the same evenings upon similar conditions.

This liberal policy on the part of a learned society will be much appreciated by Dental students, who are not eligible for membership until they are qualified.

The above-named privileges will be in force during the whole of the current year, and at its termination it is to be hoped that the society will continue to grant these concessions, which must prove of great educational advantage.

"Charles Murchison" Scholarship in Clinical Medicine.

The next Examination for this Scholarship will be held at the Royal College of Physicians of London, on Monday, the 9th day of April, 1894, and following days.

The Scholarship is open to any Student of Medicine who has been a registered Medical Student during a period of not less than four, and not more than six years at a Hospital in London or Edinburgh, recognised by the Royal College of Physicians of London, or by the Medical Faculty of the University of Edinburgh, and whether holding a medical qualification or not.

The examination will be conducted both orally and in writing, and will include—

(*a*) Examination of Patients, with reports on their cases;

(*b*) Questions on Pathology and Treatment; and

(*c*) Examination on Specimens.

The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than March 26th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools.

(The Examination for 1895 will be held in the University of Edinburgh.)

EDWD. LIVEING, M.D., *Registrar.*

Royal College of Physicians,
London, February, 1894.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Year Limit in Inter-Hospital Football.

DEAR MR. EDITOR.—Let us have a time limit: for these reasons. We have always three or four superlatively good men in the Association Cup Team at Guy's; but they can, as a rule, be only induced to play in the cup ties or occasionally in one of the best matches. Their places have to be filled for the real work of the season, and only one who has been secretary can know how difficult a matter it is to get good men to play in the team, when they know that having borne the burden of the day their places will be filled by the "stars" when glory is to be won in the cup ties. Naturally they prefer to play for elevens who treat them with more consideration, and so we have to descend to the casual player to make up the end of our elevens only too often. This is the state of matters at present, and it would be greatly aggravated if the ranks of the "stars" were to be indefinitely added to by chronic "stars". We have had, besides, too many object-lessons in late years of the folly of at the last moment putting in a man who, however brilliant, does not "know his side," not to be warned against permitting senior men—who can, owing to their work, only play now and then—a place in our elevens.—Yours sincerely,

AN OLD SECRETARY.

A Guy's Dental Society.

SIR.—The interesting paper read by Mr. Parfitt at the last meeting of the Physical Society not only demonstrated the fact of "The Decadence of the Teeth," but also the deficiency of dental debate. It was really lamentable how little the dental men present contributed to the discussion. Now, it seems to me that it is not necessary to seek far in order to discover the cause of this defect; I find it in the lack of a Students' Odonto-Chirurgical Society in connection with the Hospital, at whose meetings casual communications might be presented, papers read, and even dental clinics arranged. With a special school within the walls of so great a hospital as our own, there are exceptional opportunities for making such a society a great success, obtaining—as I have no doubt we should do—the aid of our medical colleagues in the discussion of those cases which are on the border-land of dental and general surgery. Now, sir, I am conscious of many objections which may be advanced against the carrying out of such a scheme as is here hinted at, but if this letter elicits the opinion of your readers, the object for which it is written will be in a measure achieved.—Yours, etc.,

MONTAGU F. HOPSON.

February 17th, 1894.

An Interesting Case.

DEAR SIR,—Your invitation to country subscribers to send cases does not seem to meet with much response, and yet I think much of the "piffle" of private practice has an interesting side. The following, though a trifling case, seems to me to have both theoretical and practical interest:—Mrs. H., æt. 74, farmer's widow, healthy and active for her age, sent for me the other day. She had been confined to bed for three or four days with rheumatism. She was first attacked with severe lumbago; in a day or two she noticed a very large deposit of lithates from the urine, and a day or two later an acute synovitis of the right knee came on. As "embrocation" did not cure the knee, I was called in. There was no rise in temperature, and no bruit, but the rythm of the heart was upset, it beat in triplets of perfectly "regular irregularity"; a strong beat, a weaker beat, and a very weak one. The urine deposited an enormous quantity of lithates; there was very severe lumbar pain, and the right knee was distended with fluid and very tender and hot; all other joints normal. On Sod. Salicyl. gr. x. every four hours the urine cleared up in twenty-four hours; the knee was well in two days, and the lumbago much relieved in three or four days. The heart was beating normally on the second day of treatment. It is now two months since the first onset; there has been no return of the synovitis, but twice, on leaving off the salicylate, lumbago has become aggravated, to be again eased by the medicine, though never quite cured.

I ought to mention that it is now exactly three years since this patient was operated on in Lydia, by Mr. Lucas, for carcinoma of the breast (with deposits in axillary glands). She still remains perfectly free from recurrence.

S. W. MACILWAINE.

Lying-In Charity.

DEAR SIR,—As the "chief offender" alluded to by your correspondent "Extern," I was not meaning to notice his letter, but I feel that perhaps some apology is due to "Extern" and his confrères, which I heartily tender. Let not the uninitiated, however, suppose that the writer was the only—if, possibly, the chief (?)—offender in this direction during the last few months. Far from it. He was, however, the only one who had the decency to initial every card so obtained, implying a (to his puny intellect) sufficient reason for so doing. In every case the patient was informed that it was a special favour, and that she must not expect as much attention as if living nearer. The touching way the Borough *gravidæ* plead for the obstetric good offices of "a nice gintleman from Guy's 'Orspital" is to a tender-hearted Charity well nigh irresistible. The *bouleversement* attributable to the universal change in nomenclature of every street and alley in South London will account for

some mistakes. Considering that in the present overcrowded condition of the Medical School the appointment of Extern is almost the only one in which one has the chance of examining the patient without being hustled and jostled off one's legs, the writer has always held that a concurrent increase in the number of cards issued would be only rational. Two years ago, when the writer was a footsore Extern, more cards were attended during the month than during your correspondent's month, and this without the Junior Charity being ever summoned to a normal case, although there were never more than five (and for a week or so only four) Externs on duty instead of six, as there invariably are now.—With apologies for gas, yours truly, DIOGENES.

Sport.

Association Football.

GUY'S v. ST. MARY'S.

RE-PLAYED TIE.—SECOND ROUND OF THE INTER-HOSPITAL ASSOCIATION CUP.

After becoming reconciled to the disappointment of having our career in the above competition cut short, despite the fact that we had hoped for better things, it was an agreeable surprise to find that the United Hospitals' Committee had ordered the Tie to be re-played, Moon, one of the Mary's backs, having been declared ineligible owing to his having transgressed the five years' limit. The match took place in splendid weather, on the 15th instant, at Wimbledon, the Polytechnic Football Club's ground, which was in first-rate condition, being the scene of the encounter.

As Mary's were of course weakened by the absence of Moon, and Guy's, profiting by past experience, had attempted to strengthen that weak spot, the forwards, by replacing Pendred and Davies by Hibbard and Waymark, neither side felt very confident as to the result, and a tough struggle was anticipated. As soon as the ball was started it became evident that such was to be the case, a very fast and exciting game ensuing, which was in no way so one-sided as the result—four goals to love in our favour—seems to indicate. The play on both sides was of the highest order, and where Guy's shewed the supremacy was in the brilliant display of the back division, who, one and all, played a most excellent game. The display of our forwards also contrasted markedly with their feeble exhibition in the previous tie, the inclusion of Hibbard, who went off at a rare pace, seeming to endow them with some of the dash which was lacking on that occasion.

The Mary's forwards perhaps on the whole shewed the better combination, being quicker on the ball, and were more forward as regards training, but all their efforts were frustrated by the defence of our backs. Of these, although where all played so well it is invidious to particularise—and we should have to mention each one in turn—special mention must be made of Carter's brilliant play at full back, and Hewetson's untiring energy at half. It could hardly be expected that the combination of our forwards should be perfect, as they have not played together before, yet it was, as stated, a great improvement on previous form. Hibbard scored all our goals, his shooting being of great service, and Fitz-Hugh having someone to back him up, played, perhaps, more like his old form than he has in one or two matches lately. Stamford played exceedingly well, doing far more work than he usually does, while Walker, although making several mistakes in the first half, was decidedly useful. If we are to beat Bart.'s, however, in the next round, further improvement must still be shewn, especially as regards combination, which could be decidedly improved with some more practice, while strict training will also be essential. The Guy's "crowd" turned up in better force, and this time there was no fault to be found on that head.

Coming to details of the match, Guy's lost the toss, and Fitz-Hugh, punctually at three o'clock, kicked off against what little wind there was. Hibbard at once dribbled into Mary's quarters, but passing to Walker the latter centred wildly and the ball went behind. Soon after hands was obtained opposite the Mary's goal, and Hibbard put in a splendid shot, which the goal-keeper cleared, but Hewetson, catching the ball in the volley, returned very smartly, the ball only just going behind. Mary's now began to play up, obtaining a corner, which was unproductive, shortly afterwards followed by another. Each goal was threatened in turn, Sworder causing Lavers to use his hands, while Fitz-Hugh shot behind. After Mary's had forced another corner, Guy's broke away and began to press considerably, Hibbard, from an excellent pass by Crosby, putting in a hot shot, just skimming the cross-bar. Mary's forwards now were playing an excellent game, Pares and Lening shewing some very pretty combination, and Lavers had to save several times. Stamford, however, managed to get away on the left, and passing to Fitz-Hugh, who in turn passed to Hibbard, the latter scored the first point for Guy's, rushing the ball through. Guy's continued to press, Stamford being conspicuous, while a little later Fitz-Hugh, receiving a pass from Hewetson, put in a grand shot, which the goal-keeper muffed, when Hibbard rushing up, put the ball through. Fairly even play ensued up to half-time, which arrived with Guy's leading by two goals to love.

On resuming, even play ensued for the first ten minutes, when Guy's forwards began to "slack," and Mary's pressed considerably, a free kick being awarded to them in front of our goal, which luckily proved ineffective. Our backs had a busy time, the forwards not getting back soon enough, and Lavers had to save several hot shots, which he proved quite equal to. Stamford now got away on the left, and making a brilliant run the whole length of the field centred finely, and Fitz-

Hugh and Hibbard rushed the ball through, scoring our third goal. This seemed to dishearten the Mary's forwards, and Guy's again began to have the best of the game, obtaining several corners. Mary's made several rushes, one of which Cooper pulled up brilliantly, and passing to Waymark, who transferred to Hibbard, the latter scored, putting in a splendid shot, which completely baffled the goal-keeper. Guy's continued to have the best of matters up to the call of time, which occurred during a hot attack on the Mary's goal, several very tall shots being sent in. Appended are the names of the team:—

GUY'S.—N. Lavers (goal); F. J. Liddердale and A. B. Carter (backs); H. Hewetson, N. C. Cooper and A. E. Crosby (halves); F. E. Walker, C. E. Hibbard, R. T. Fitz-Hugh, W. E. Waymark and R. B. Stamford (forwards).

GUY'S v. MAIDSTONE.

This match was played at Maidstone on February 10th, in the presence of a crowd of several hundred enthusiastic supporters of the home club. Hewetson won the toss, and elected to play up hill and against the wind, which all through was very high, and interfered with the passing a good deal. Ours was a strangely constituted team, as four members of the second were included, while two of the regular team had to play out of their usual places, Crosby going full back and Stamford left inside. Maidstone kept the ball in our half of the field a good deal at the start, and Lavers had a busy time. He played a cool sound game, and stopped many good shots, until their outside right, after a fine run, put in a centre, and enabled Maidstone to score a good goal. Our forwards made frequent runs, but the wind bothered them a good deal, and nothing came of their efforts, although they became dangerous on more than one occasion. Half-time came with the score one goal to nil against us.

It was now our turn to have the wind in our favour, and in consequence we did all the pressing. On the kick off, Stamford and Fitz-Hugh made a good dribble right down the centre, and looked likely to score, but Fitz-Hugh was too slow, and lost a good opportunity. Most of our forwards made good shots, but Waterman, their goal-keeper, played a very fine game, and kept them all out. We took several corners about this time, but could make no use of them, and it was not until Hewetson had a try that we got one in the front of goal. After the second half had been in progress about twenty minutes, Fitz-Hugh made a shot, which Waterman caught and threw away to the feet of Stamford, who, with a sound effort, landed the ball into the net, and made the score equal. Playing up with renewed energy, we tried hard to get the lead, and had it not been for Waterman we should have won easily, but he played splendidly, and saved several shots which most goal-keepers would have let through. Time arrived with the score one goal all, a fairly satisfactory result, considering the somewhat motley team which represented us—indeed it was not until about half an hour from train time that the unfortunate hon. sec. was able to get eleven men together. Team:—

GUYS.—N. Lavers (goal); A. E. Crosby and E. A. Longhurst (backs); R. Hayes, H. Hewetson (captain), and G. Crewe (halves); E. Picnot, R. B. Stamford, R. T. Fitz-Hugh, B. F. Pendred, and F. E. Walker (forwards).

Our record is—Played, 16; won, 8; lost, 5; drawn, 3. Goals for, 40; against, 29.

GUY'S 2ND XI. v. CRICKLEWOOD.

This match was played at Cricklewood on Saturday, February 17th, in very bad weather, rain falling the whole time. In spite of the fact that we only played nine men, two having failed us at the last moment, we managed to score an easy win by five goals to one. The goals were kicked by Davies (two), Edey (two), and Brookhouse (one). All our men played a good game under the adverse circumstances. Team:—

GUY'S.—King (goal); Longhurst (back); Crewe and Cogan (half-backs); A. Miller and R. G. Edey (right), E. J. Davies (centre), R. O. Jones and C. S. Brookhouse (left), forwards.

Rugby Football.

LEICESTER v. GUY'S HOSPITAL.

From the *Leicester Daily Mercury*.

The Leicester Football Club executive are to be congratulated upon the large number of fixtures arranged this season with London clubs of high standing. It was expected that one of the most popular of these would be the match with Guy's Hospital, who gave Leicester such a capital game last year, and it was extremely unfortunate that the event should have clashed with the important English Cup Tie "over the way." This, naturally, had considerable effect on the gate, which no doubt would otherwise have been an exceptionally good one. As it was, a very fair number of spectators lined the enclosure last Saturday, 10th inst., and the visitors were accorded a most hearty reception as they entered the field.

It will be remembered that in the match last year some fine open play was witnessed, and after an exciting finish, the game resulted in a draw of eleven points each. This season, Guy's have not been going quite as strong as usual, and as last season they were beaten by St. Thomas's—with whom Leicester played a drawn game three weeks ago—there was a feeling among the supporters of the home club that the latter would, with a representative team, secure a favourable verdict. Unfortunately, a number of the Leicester men were unable to turn up, several being absent through injuries. In the forward ranks, Banks and Rendle were absentees, and the three-quarter line lacked the services of Watts. It was consequently decided to fall back on the three three-quarter back system, and E. Swain, A. Harlowe, and W. Burton, were selected to play in the forward division. The

wind was blowing a perfect gale from the Aylestone-road end, and as Cooke won the toss, the home team had a considerable advantage in the first half.

Guy's kicked off at 3.35, and owing to the wind holding the ball in the air, Hesmondhalgh was partially prevented from getting in his kick in return. The home forwards rushed away, however, and looked like scoring, but were called back by the referee's whistle, a scrummage being formed in Leicester's half. Simpson passed out nicely to Hitchcock, who tried to put in a touch-kick, but Alexander secured possession, and returned well to the half-way line. Hereabouts the visiting forwards gave a pretty exhibition of passing, which nearly resulted in Bell getting through, Day, however, proved equal to the occasion, and bringing down his man in fine style, the home forwards again got away, and as this was followed up by some clever passing among the backs, Leicester got a footing in Guy's half. Hesmondhalgh gained more ground with a fine kick, and following up well, Hitchcock appeared to have a chance on the left wing, but he was pushed into touch. A bout of Leicester passing was spoiled by Bell intercepting Simpson's throw, but as the Guy's man failed to get away, very little ground was lost. Scrummaging went on inside the visitors' twenty-five and in this department of the game Guy's showed the best form, the men heeling out in fine style. Off-side play by one of the Leicester halves was penalised, but the kick was of no avail, the game going on in mid-field. Up to this time Leicester had certainly shown no superiority, Guy's having had if anything the better of the play. Loose play in mid-field ended in favour of the visitors, who rushed up with irresistible force, and Bell, picking up a few yards from the line, had no difficulty in getting over for a capital try behind the posts. The extra points were easily added, and Guy's were thus given a substantial lead, though playing against the wind. Going on, play settled down in the visitors' half, where Bell was again conspicuous with a fine run and kick. Grand foot play by Touhey took the game into close proximity of Guy's line, but the visiting forwards dribbled back until cleverly stopped by Harry Simpson. Foreman now got the ball away with a high kick, and Alexander failed to get in anything like a good return. This gave Leicester another chance, but the Hospital forwards were playing an exceedingly good game, and were not long in taking play back to the half-way line. Here Foreman was seen to advantage, and Jackson stopped a forward rush in a very plucky manner. Simpson gave Hitchcock a nice pass in mid-field, but the last-named was unable to get away. A long kick by Foreman immediately after this forced a dead ball, and a minute later the visitors had to concede another minor. The character of the play had now very considerably improved, being much faster and more open than in the previous stages. Still Leicester altogether failed to come up to expectations, the visiting forwards for the most part commanding possession of the ball. A free to Leicester for some infringement on the part of the visitors transferred operations to Guy's half, where a moment or two later a stoppage occurred through an injury to Jones, one of the Guy's halves, who had to retire from play. Proceeding, a grand piece of play on the part of Hesmondhalgh took the game well into Guy's half, and clever tackling by Vity prevented the visitors getting away. From a position within Guy's half, Wilkinson got hold, and very nearly ran in, being held by Alexander just on the line. From the scrum which followed, Leicester had a splendid chance of scoring, but the passing was faulty in the extreme, and as a result the visitors obtained relief to the half-way flag. Foreman here handed out to Hitchcock, who got in a beautiful touch-kick when in difficulties. This was immediately followed by a pretty bout of passing among the Leicester backs, initiated by Simpson, but nothing tangible ensued, and half-time arrived with the score:—

GUY'S HOSPITAL, one goal (five points).
LEICESTER, nothing.

Playing with the wind in the second half, there appeared every probability that Guy's would add considerably to their score. Cook's kick, however, was not returned, and the Leicester forwards going away with a rush, very nearly reached their opponents' line within a minute of the re-start. Alexander saved well, but the visitors were penalised for off-side play, and Leicester had a fine opportunity of scoring. Cook took the kick, but the ball was carried wide by the wind. The Tigers following up in grand style, pinned their opponents to their own twenty-five, and another free was awarded them near the touch line. No goal resulted, but Wilkinson brought down Stewart before he could return. Still Leicester pressed, and some grand passing was indulged in among the home backs, as a result of which the Tigers were able to keep up the hot attack upon the visitors' goal line. Hesmondhalgh was conspicuous with a tricky run, and his pass to Hitchcock should have brought forth a try, but the last-named was brought down before he could get a yard away. Clever play by Mathias behind the scrum brought relief to Guy's, but Simpson and Hesmondhalgh in turn stopped rushes which looked dangerous for Leicester. At this point Jones returned to the field. The home team forwards were now playing a much better game, and more than held their own in the scrum. Gradually the visitors were forced back on their own line, and once more the Tigers looked like scoring, but relief came through a long kick to mid-field. From here the Guy's forwards went off with a splendid rush, and Bell picking up at the twenty-five flag rounded a number of opponents, and secured a beautiful try in close proximity to the posts; a nice low kick bringing the visitors' score to ten points. A minute from the re-start Day failed to take the ball from a high kick, and Dudgeon, one of the visiting forwards, rushing up, took the ball and ran in without opposition for an exceedingly fluky try, which was easily converted. Going on, some nice passing between Simpson and Hesmondhalgh was seen, and Wilkinson

was given possession, but spoiled the effort with a wild throw. Despite the heavy score against them, the Leicester men were playing a really plucky game, and notwithstanding the wind kept Guy's for some time confined to their own half. Here the Tigers were afforded another free, but nothing tangible resulted. Fast play went on in mid-field, but very little combination was shewn on either side, and the game was consequently of a very scrambling nature. Foreman, Hitchcock, and Wilkinson then participated in some smart passing, by means of which they reached Guy's twenty-five. Some very exciting play ensued, the ball traversing rapidly from one side of the field to the other, and more passing by the home three-quarter line made matters look dangerous for the visitors. Still the Tigers were unable to score, and a long kick by Jones took the game back to the home half, where Cooke and Touhey were prominent with some fine forward play. Hesmondhalgh intercepted an opponent's pass, and had very hard lines indeed in being called back just when he appeared to have a chance of scoring. Again Leicester attacked strongly, and Hitchcock made a fine run on the wing, and was only pulled down by Alexander when he had nearly reached the Hospital line. The visitors relieved with a long kick, and as Day failed to gather the ball, Guy's looked like scoring again, but Wilkinson happily kicked into touch. Running and passing by Foreman and Hesmondhalgh chiefly once more transferred operations to the Hospital twenty-five. Smart play by Jones took the leather back into Leicester's half, and a foolish kick by Hesmondhalgh caused the ball to be blown very nearly to the Leicester line. The home forwards got the ball away at their feet, and more fruitless passing was indulged in by the Leicester back division, the game ended shortly afterwards in mid-field, the total score being:

GUY'S HOSPITAL, three goals (15 points).
LEICESTER, nothing.

REMARKS.—It would be a great mistake to suppose that Guy's were 15 points better than the home team, even on the afternoon's play. Two (?) of their tries were gained by extremely fluky play; and in regard to the other, it is alleged that the try-getter was off-side. Be that as it may, the Tigers were certainly equal to their opponents in the loose play, and in point of time they really did more attacking than their opponents. The home defence was, however, very weak, and, as usual, the element of scoring power was conspicuous by its entire absence. Many times the Leicester men drove the visitors back upon their own line, and just when it appeared certain they would score, the Guy's backs would relieve with some smart touch kicking. Among the Leicester forwards Messrs. Touhey, Cooke, Vitey and Carey were prominent in the loose work, while among the backs Messrs. Foreman, Simpson and Hesmondhalgh put in some good work. Hitchcock's opportunities were mostly spoilt by bad throwing—caused probably by the wind—and Wilkinson was only good in defensive play. The best three-quarter back on the field was undoubtedly Bell, the Guy's centre, who was far ahead of the rest in speed, skill, and resource. Jones, at half-back, also played a capital game. Teams:—

LEICESTER.—G. Day (back); Rev. H. C. Wilkinson, H. Hesmondhalgh and A. E. Hitchcock (three-quarter backs); W. J. Foreman and H. J. Simpson (half-backs); A. E. Cooke (captain), W. Jackson, A. Akers, Rev. W. H. Carey, E. Vity, J. Touhey, E. Swain, A. Harlowe and W. Burton (forwards).

GUY'S.—K. B. Alexander (back); F. C. Wetherell, H. T. Bell and H. M. Stewart (three-quarter backs); R. Mathias and M. P. Jones (half-backs); E. T. Shorland, F. O. Stoker, R. S. Rowland, E. D. Hancock, H. W. Dudgeon, L. Slater, W. Tyson, C. D. Edwards and C. R. Nicholson (forwards).

Referee: Mr. A. Hartley, Castleford, Yorks.

GUY'S v. KENSINGTON.

This match was played on Saturday the 17th, at Honor Oak Park. The weather was of the worst description and the game throughout was played in torrents of rain. The match was a fairly even one, but mostly confined to the forwards, the wet state of the ground and ball making it impossible to play the passing game among the backs. Kensington won the toss, and Stoker kicked off for Guy's against the wind; after some give-and-take play the Guy's forwards made a good rush, and Nicholson picking up close to the Kensington line, passed well to Rowland, who scored a try, which proved to be the only point scored during the match: Shorland made a good attempt at goal, but the greasy ball went just wide of the upright. Kensington now played up well, and nearly scored, one of their men being collared almost on the line, but the referee ruled "held outside," and a scrimmage was formed five yards out, when the Guy's forwards getting the best of it, were enabled to relieve the pressure; soon after the whistle blew for half-time.

The second half of the match was still more scrambling than the first, as the ground was getting heavier and in worse condition every minute. Play was fairly even, and nothing more being scored, Guy's won by one try (three points) to nil.

REMARKS.—The game was a good one considering the unfavourable weather, and the Guy's forwards showed a good deal of dash, evidently the result of training for the Cup ties. Of the Guy's backs, Jones was in good form, and Wetherell played a sound game, Bell also doing some good defensive work. Among the forwards, Stoker, Nicholson and Rowland were the pick. For Kensington, Moore played hard at centre three-quarter, and of the forwards, N. Instone was decidedly the best.

GUY'S 2ND XV. v. ST. BARTHOLOMEW'S 2ND XV.

This match was played on our ground, on Saturday, February 10th. As usual, a high wind blew almost straight along the ground, and accurate passing and kicking were therefore seriously interfered with. In spite of

the elements, however, our backs brought off one or two really pretty pieces of play, equally astonishing and delighting the onlookers thereby, the best being a series of passes which resulted in Moore getting in. The forwards—well! eight men all talking at once, and all shoving in different directions. Fortunately for us, the St. Bart's team was a very weak one (five of their usual 2nd XV. having been kidnapped for the 1st), without even a rudimentary idea of the game, and after an hour's "go-as-you-please" sort of sport, our score amounted to two goals and five tries (twenty-five points) to nil.

From the kick-off Guy's pressed, and within a very few minutes a beautiful piece of passing—in which both halves and all the three-quarters took part—resulted in Moore getting over and grounding in a good position: the shot at goal failed. Very soon after the drop out, Walling secured the ball from a long throw out of touch, and passed to van Someren, who had no difficulty in scoring between the posts, but again the place kick was unsuccessful. On resuming, Guy's continued to do as they pleased, and two more tries were added before half-time, van Someren and E. Morgan both scoring in beautiful positions. In each instance the place kicks were the most miserable of abortive attempts, the ball rising about four feet from the ground.

The second period was more of a farce than the first had been. Our team, with the wind behind them, scarcely ever left the Bart.'s twenty-five, and Hicks ran over the line whenever he wished, scoring twice between the posts, and a third time near the lower touch-line. Moore had no difficulty in converting the first and second, and Hicks made an excellent attempt to improve upon the third, the ball just missing the left-hand upright whereupon the band played—we mean the whistle sounded—for "no side." Team:—

GUY'S.—A. B. Muriel (back); H. Walling, E. H. van Someren, T. Morgan, and J. Moore (three-quarter backs); E. Morgan and H. T. Hicks (half-backs); A. J. Cleveland, G. N. Mottram, C. C. Stead, E. G. Goddard, W. Dykes, N. H. Pike, V. E. Collins, W. J. Lindsay (forwards).

GUY'S 2ND XV. v. KENSINGTON 2ND XV.

Played on Saturday, February 17th, on our opponents' ground at Wormwood Scrubbs under the most miserable conditions, a drenching rain falling throughout the afternoon. Guy's, as will be seen below, were minus the services of no fewer than four of their back division, Hicks having been taken for the 1st XV., and three others having with one accord made excuse, and made their way to keep far more pressing engagements, one preferring gastronomic feats to his usual Saturday afternoon's performance of scoring tries; another giving his services to an outside club. Patriotism, *esprit de corps*, etc., are evidently played out.

Guy's won the toss, and played with the rain and wind at their backs for the first half. From the outset our forwards had the best of matters, and soon worked the ball to the home twenty-five, whence Dykes came through a scrum with the ball and dribbled over, but unfortunately kicked the ball dead. After the drop out, Kensington fared a little better, and a rush of their forwards took the ball to the half-way line, where Lindsay stopped them in fine style. Both sides were awarded free kicks for off-side play, but no good resulted from either, and the remainder of the first half consisted almost entirely of scrums, Guy's having generally the upper hand. From the kick-off a number of exchanges resulted in the ball going into touch at the Kensington twenty-five line. Morgan threw out against Henry's shoulder, and, taking the ball himself as it rebounded, ran in after a neat, dodging run, and grounded about half way out. Cleveland converted nicely. On resuming, Collins, Cleveland and Goddard came away from a scrum and dribbled down, but only a minor resulted. Shortly afterwards, Cleveland and Simson executed another good dribble and seemed certain to score, but the ball was kicked over the line by a Kensington man. From the ensuing scrum the ball was taken opposite the Kensington goal, but repeated attempts to score were of no avail, and a free kick for off-side (a doubtful decision) gave some relief. Soon Guy's in turn were awarded a free kick, and Cleveland made a good shot, but just as a goal seemed certain the wind carried the ball outside the post. After kicking out, Kensington made a dash right up the field, but kicked too hard and allowed Muriel to touch down. Soon each side was awarded yet a third free kick for off-side, but neither could score, and "no side" was called with Guy's again pressing. The game thus resulted in another victory for our team by five points to nil. Teams:—

GUY'S.—A. B. Muriel (back); T. Landen, H. Walling, W. T. Clarke (three-quarter backs); E. Morgan, N. H. Pike (half-backs); A. J. Cleveland, V. E. Collins, G. N. Mottram, A. H. M. Saward, E. G. Goddard, W. Lindsay, W. Dykes, J. H. Simson, C. H. Fagge (forwards).

KENSINGTON.—H. A. Weekes (back); W. J. Larnack, N. Lewin, A. D. and H. W. Bayliffe (three-quarter backs); P. F. Henry, H. M. Eames (half-backs); H. R. Warner, R. E. Tyler, A. K. Lofts, L. T. C. Smith, G. M. Swanson, A. R. Bartleet, C. A. Weekes, J. F. Dempster (forwards).

Births.

HOLMES.—On the 11th February, at Forton, the wife of Thomas Holmes, M.B. Lond., of a son.

WASHBOURN.—On the 11th February, at 15, Trinity Square, S.E., the wife of J. W. Washbourn, M.D. Lond., F.R.C.S. Eng., of a daughter.

Death.

MEDWIN.—On the 10th instant, at Folkestone, A. George Medwin, M.D., of Bruton Street, Berkeley Square, W.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual subscription to the Gazette *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers, who may be desirous of having their numbers of the Gazette *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette,

MARCH 10, 1894.

Dropsy.

CLINICAL LECTURE by Dr. PYE-SMITH.

Gentlemen,—Since my last lecture there have been several interesting cases.

(1.) One was a girl admitted with apparently extreme distress and rapidity of breathing. She was not cyanotic, and when lying down breathed just as well (or as ill) as before. There was no evidence of heart disease or of any other of the causes of dyspnœa in the lungs or the blood. Her condition was not really a want of breath, but a getting out of order of the respiratory centre in the bulb, resulting in increased frequency of shallow respiration: this is called "hysterical dyspnœa" as distinguished from *true* dyspnœa.

(2.) Another very remarkable case was one admitted under Dr. Taylor. The patient had very severe and sudden pain, vomiting, collapse, and then all the symptoms of peritonitis, and was very ill indeed.

These cases often come before us; they are very anxious ones for the physician and fraught with danger to the patient. Such acute and severe peritonitis may be due to perforation of one of the hollow viscera, either the *stomach* by an ulcer, or the appendix *cæci*, or the small *intestine* in late typhoid fever, or the bladder, or the gall bladder; any of these cavities may become perforated and excite acute and generally fatal peritonitis. Dr. Taylor inclined to the belief that the case was one of gastric ulcer. I, partly misled by the history, thought enteric fever the more probable. It turned out clinically to be gastric ulcer, although anatomically it was not a gastric, but duodenal ulcer. These cannot be diagnosed from one another, their symptoms, and probably pathology also, being exactly the same.

The first part of the duodenum contains acid material, just as the stomach does; the second and third have alkaline contents, and it is only in the first part that these ulcers occur, as the one did in this case.

There is not much to say with regard to *Treatment*. There are two courses open to us in these terrible cases.

a. *Laparotomy* and exploration, and attempt at treating the perforation surgically.

b. The other plan is to relieve pain and give a possible chance of recovery by full doses of opium. This patient nearly died from opium-poisoning, but recovered from that and died from septic peritonitis.

(3.) Another remarkable case was a man of about 50. He looked at least ten years older, was much emaciated, had great distress and vomiting. He had a clear, healthy complexion. By trade he was a milkman, and by practice a spirit drinker.

He had not suffered until August, when he was sick and vomited blood. There was also melæna, which always means hæmorrhage from the stomach, not from ileum or colon. The liver was somewhat enlarged, and the abdomen hollow. There was no jaundice nor ascites. Great emaciation, but not much pain.

In such cases there may be one of three conditions—

a. *Ulcus ventriculi*, rather more common in women than men, and especially in servant girls; but far from rare in either sex, and at any age, up to seventy or eighty.

b. *Cancer of stomach.*

c. *Cirrhosis of liver.*

On the whole we thought there was no gastric ulcer because pain was slight and hæmatomesis not great. We did think it was *cancer.*

He was very emaciated and about the right age.

It might have been cirrhosis, but he had neither jaundice nor ascites. Always beware of being certain of a diagnosis which depends on probability; here was a man who drank heavily and there was great probability of cirrhosis; but because a man is a drunkard he is not thereby exempted from cancer, just as colic in a plumber may be due to hernia, and blindness in an hysterical girl to tumour of the brain (cases in illustration).

He died, and his disease turned out to be a large cancer in the duodenum, close to the pylorus; and also a still larger growth, quite separate from the first, a short distance further.

This is a pathological curiosity; you do very occasionally see a woman with both breasts cancerous, but a case of two independent carcinomata (not sarcomata) is exceedingly rare. Probably one was derived by direct infection from the other.

We will occupy the rest of our time to consider the diagnosis and treatment of the several kinds of dropsy.

The word itself is a corruption of "Hydropsy," and the English terms are "water on (*i.e.* in the ventricles of) the brain" (Hydrocephalus); "water on the chest," *i.e.* in the pleura (Hydrothorax), or on the heart (Hydropericardium); water in the abdomen (Ascites); in the tunica vaginalis (Hydrocele); the subcutaneous tissue (Anasarca).

1. There are two conditions that are spoken of as effusion of "water."

If you injure your finger or have a boil, you will find that all round the inflamed part there is a ring of œdematous tissue; this is an exudation of "water," which, if the part be pricked, will flow out. This is a different kind of effusion from that of dropsy, which is a *passive* œdema. It is, however, often difficult to draw the line; you sometimes find after death "water" on the chest that is clear serum, with the pleura quite normal. More often you will find evidence of inflammation in thickened opaque serous membrane, "false membranes" of fibrin, and turbid or purulent or perhaps bloody serum.

What is the immediate mechanism? You see a man with a swollen arm, and you at once look to see if there has been anything to press upon the great vein returning the blood from the arm, and you generally find something of the kind, either the presence of a tumour or the use of a crutch.

Try this in the laboratory: tie a rabbit's femoral vein and you will find that the lymphatics take up all the exudation and drain it off, and so prevent œdema. If, however, the lymphatics also be ligatured, dropsy occurs. When you get dropsy in an animal you can relieve it by moving the limb about and hastening the return of the lymph. The dropsy is also considerably affected by dividing or not dividing the principle nerve and the limb, so there is probably some nervous influence concerned.

Therefore dropsy depends largely upon pressure on a vein and not much on *osmosis*. Osmosis (described by Graham) is the process by which two fluids gradually diffuse through a membrane. The most rapidly diffusing substance is hydrochloric acid, then come various saline substances, and then peptone, and presently albumins, gums, and other substances called "colloids" which hardly diffuse at all. This, however, has nothing to do with diffusion through a membrane under pressure, which is what takes place very largely in the body. The researches of Heidenheim (?) have shown that it is not merely the result of pressure in a mechanical way, but depends upon the actual secretion of the indothelial cells that line the lymphatic spaces.

Remember, then, that the pathology is somewhat obscure, and do not be too sure of everything by mechanical action. Remember also that in many cases there is a certain amount of inflammatory exudation along with the passive dropsy.*

Diagnosis and treatment of the different kinds of dropsy.

I. *Local.*—If one arm is swollen it probably depends upon pressure on the axillary vein. Both legs may in like manner be swollen from pressure on or blocking of the inferior vena cava. Or the whole of one side of the face and neck may be dropsical. There was such a case lately in Philip ward (No. 21). The man was apparently in good health, but œdema of the arm and of the same side of the face and neck had appeared, due, no doubt, to thrombosis of one of the great veins, probably the right innominate, as many of the vessels of that side of the chest were large and varicose; the external mammary vein, which ordinarily would be invisible, was swollen as large as the saphenous where it enters the femoral.

These cases almost always depend on local pressure, and are generally relieved by removing that pressure.

When the head and neck are affected you cannot get at the cause. Sometimes relief may be given by puncture, and in all these cases, where possible, it is well to take advantage of the action of gravity; if you have an œdematous hand, keep it raised by a sling: if swollen ankles, keep the patient lying down with the feet higher than the pelvis.

II. *Portal.*—In many cases portal dropsy is due to cirrhosis of the liver. Whatever the cause may be, it squeezes the trunk of the portal vein, and raises the pressure in the capillaries. You will know it at first sight, because the dropsy is *below the diaphragm.* The abdomen is first affected—producing ascites, then the legs by pressure on the vena cava. I had a patient once with ascites and dropsical legs, who declared the legs swelled first, and the only way to a diagnosis was to disbelieve her. She would probably notice the swelling of the feet first by the boots getting tight. As a matter of fact, the abdomen always swells first, there is no swelling above the diaphragm, and the genitals are unaffected.

Why do we not get hæmorrhage into the peritoneal cavity? Hæmorrhage occurs into the stomach in cases of cirrhosis, why then should exudation of serum occur from the same cause in the peritoneum? I cannot answer the question. All I can say is, that dropsy seems to be an affair of the lymphatics, and whenever you have endothelial plates there you have dropsy, as in the pleura, the peritoneum, the pericardium, and the tunica vaginalis, all parts of the great pleuro-peritoneal cavity, and of the same constitution, being great lymphatic spaces. Those are the chosen sites of dropsy. It also occurs under the skin and mucous membrane, the submucous and subcutaneous tissues being full of lymphatic spaces, and containing large quantities of adenoid tissue. So we may compare the presence of dropsy in subcutaneous and submucous tissue and the serous cavities, with the absence of it in the solid viscera, the skin itself, cartilage, bone, etc., which are strikingly free from dropsy, all excepting the lungs, which are full of lymph spaces.

Treatment.—As soon as the abdomen is full, tap it. If you can relieve the condition, and the cause is not irremediable, you may give a tolerably good prognosis.

You may cure it if you can persuade the patient to give up the habits which led to it. The means to be adopted are:—First get rid of the effused serum by tapping, or by draining off through the three great emunctories—the kidneys, the skin, and the bowels; the lungs ought to help, but there is no means of greatly increasing their excretion of watery vapour. On the other hand, the bowels, which in health only give off a small

* Those interested in the physiology of œdema should read Dr. Starling's papers on the subject in the Physiological Journal, and also a Paper by Dr. Lazarus Barlow, lately read before the Royal Society.

quantity of water, can by active purging be made to get rid of large quantities (cases of dropsy cured by cholera).

As soon as the ascites is marked it is time to tap; after tapping give drugs; they will then give a much better result. The best are diuretics, any one almost will do; you may turn from one to another, only take care that they act; measure the quantity of urine, and see that it is increased by the drug; drugs that may be given are such as *acetate of potash, resin of copaibâ, digitalis, and squill*, or abundance of water; a very pleasant one is lemonade with sugar and cream of tartar in it. There was once a navvy in Clinical ward who refused to be tapped; it was very hot weather, and this drink was given him freely; he drank it as freely, passed enormous quantities of urine, and in ten days he went out well.

Keep the bowels open with a little blue pill at night, and a little white mixture in the morning, but in cases of cirrhosis avoid violent purges, lest they should cause hæmorrhage.

III. *Cardiac Dropsy.*—Is also mechanical, and is due to pressure in the veins and diminution of it in the arteries.

It affects the whole body except the lungs, and depends upon something wrong in the force pump—the heart; sometimes adherent pericardium, usually valvular disease. You can recognise it by its occurring over the whole body. The feet swell first, that however does not help you much; but cardiac dropsy affects the arms, whereas the portal never extends above the diaphragm. If you see swollen arms and legs you know it is either cardiac or renal. It sometimes affects one side—that is due to the way the patient lies, and may alter from day to day. The head will be swollen if he is lying low down in the bed. In addition you have ascites and more often hydrothorax.

There is a form of cardiac dropsy not immediately depending upon mitral disease, which is very much like this, but different in pathology, inasmuch as it is secondary

The right side of the heart dilates in consequence of pulmonary obstruction, due generally to emphysema or to chronic bronchitis or occasionally to old cases of phthisis. This is just like the ordinary cardiac form except that it is not so severe.

There is a very interesting form which Dr. Fagge explained as cardiac, although it is generally put under the head of renal. In the later stages of Bright's disease you sometimes see dropsy which is not quite like the renal, because it affects the legs and follows the influence of gravity.

Dr. Fagge said that at post-mortem the left ventricle was in these cases found dilated, and that the condition only comes on late in the disease.

The systemic capillaries are obstructed, there is over pressure in the arteries, then the left ventricle begins to fail and becomes dilated; obstruction in the pulmonary capillaries occurs and dropsy is the result.

Dropsy of anæmia occurs in chlorotic girls. They get swelling about the ankles. This is due to weakness of the heart-muscle; the left ventricle, like every other organ, suffers from want of hæmoglobin, just as the lips are pale, the blood watery, and skin white. As the pressure in the arteries becomes low, that in the veins rises, and the resulting dropsy appears where gravity favours it, as about the ankles. If I am right, then the œdema of anæmia is also a form of cardiac dropsy.

Treatment depends upon auscultation. If one were asked for an example of curing a patient without removing the organic cause of his illness, this would be an excellent one.

You may see a patient come in swollen, waterlogged, jaundiced, and at death's door; with proper treatment he may walk out in a few weeks feeling perfectly well. There was a cabman who used to come to the Hospital in this way, and was relieved some five times, and four times returned to his employment; he died at last, but had he been in a better position he would probably have lived to a good age.

Tap if necessary; then give diuretics and moderate purges, and, above all, digitalis, which is as effectual in these cases as mercury in syphilis, or quinine in ague.

As soon as you get on to other forms of cardiac dropsy, prognosis is not so favourable.

In cases of emphysema and dilated right side of heart you seldom need to tap, but give digitalis and diuretics, and they will most likely be greatly benefited, though not so much as primary mitral cases.

In the last stages of chronic Bright's disease, with dropsy from dilated left ventricle, you may do good by giving digitalis when the pulse is cardiac (mitral) instead of renal, and along with digitalis give steel.

For the anæmic dropsy the one remedy is iron, and plenty of it.

IV. *Renal Dropsy.*—For example, in a child who has lately had scarlet fever, and is passing urine dark, scanty, stained with blood, and full of casts. This is the form of dropsy which Dr. Bright first associated with disease of the kidneys after death and albuminuria in life. The mechanism is obscure; there is no extra pressure on the veins, in fact it is the arteries that have the increased pressure.

I am inclined to the view that this acute renal anasarca is inflammatory, not passive like the œdema of the lungs or the pleurisy with effusion seen in Bright's disease. Whatever may be its nature it is very different from other kinds of dropsy. You may recognise it by the peculiarity of the urine, and by observing that it is not so much influenced by gravitation as is cardiac dropsy. It affects the whole of the body and the serous cavities, and also the lungs. Its special localities are the eyes (the conjunctiva and the lids), the loins and the genitals; the "Bright" eye, or, as he described it, the "tear that does not fall," "the lumbar cushion," and the swollen scrotum and prepuce are the three points that are the strongest evidence of renal dropsy; they seldom occur in cardiac cases, and never in hepatic.

Prognosis of acute renal dropsy is probably the best of all. You can cure it in most cases, and when cured

there is no irremediable disease left behind, as in the cardiac cases. Do *not tap or even puncture* the skin, unless it is really necessary, for dermatitis is apt to occur, and peritonitis also. Depend as long as you can upon action of the bowels and skin. Purge briskly, give brandy or ammonia, if necessary, but go on purging until you get free watery motions. As diaphoretics you may employ pilocarpine, acetate of ammonia, or the hot air bath, hot bath or wet pack. Let the patient drink freely. Do not give *mercury or opium*. In these ways you can generally get the bowels and skin to act, and then the dropsy will begin to pass off.

Hospital News.

In the Medical Wards.

NOTES FROM CLINICAL.

Miriam 24.—A. R., æt. 13. Chorea, with attacks of delirium and pyrexia.

There is a strong family history of rheumatism, and two near relatives have had chorea, one of them finally becoming insane.

The girl herself is of a highly neurotic disposition, and shews her rheumatic inheritance by frequent sore throats and the presence of a mitral systolic bruit.

A week before admission patient was very much scared by some very trivial occurrence. Choreiform movements began next day, and have steadily increased up to her admission on January 19th. She was then a well-grown, healthy-looking girl, with characteristic choreiform movements of wide amplitude, which appeared to affect every voluntary muscle of her body. She remained in this condition for two days.

Her subsequent history may, for the sake of brevity, be divided into the following periods:—

1. *Second week* of illness, in which she went quite off her head, crying out and screaming almost constantly, except when under the influence of hypnotics. Her temperature remained about 100 Fahr. the whole week, except one day, when it mounted sharply to 104, and as rapidly fell.

2. *Third and fourth weeks*, when she was again rational and quite conscious, but movements persisted.

3. *Fifth week*, when temperature again ran up to 104, and took the whole week to descend to normal. Patient again became wildly excited, taken up with visual hallucinations and unobservant of her surroundings. Sleep was only obtained with increased difficulty.

4. *Sixth and seventh weeks.* Temperature oscillated about 99, and although patient was not violent, she could not be made to respond when spoken to. The movements greatly diminished during this fortnight.

5. *Eighth week, the last.* Temperature has been down and patient has been quite rational, though she can only at present articulate, "Yes."

The best *treatment* was found to be absolute rest in the strong-room. Patient has been able to take ample nourishment in fluid form, but in spite of it has got very thin.

Many sedative agents have been found more or less useful:—

Tepid sponging reduced the temperature and greatly quieted the cerebral excitement.

Hyoscin Hydrobromate gr. $\frac{1}{200}$ was tried twice, and acted like a charm, its effect lasting about five hours, but as Dr. Hale White thought it risky to give more than two such injections per diem,

Chloral and Bromide, of each gr. x., were given from three to six times a day, as occasion required. Excellent results were obtained during the first attack of excitement, but the effect was found to be considerably dulled during the last attack. Moreover, patient seems depressed now when the drug is used, so Dr. Goodhart advised the use of

Morphia gr. $\frac{1}{6}$, to induce sleep, nightly. He says he often finds chloral and bromide to be prejudicial in such cerebral conditions.

Chloroform has been tried on three different nights when patient was at her worst—once for three hours on end, and another time in conjunction with morphia, but on no occasion did the effect last longer than an hour after the inhalation was stopped.

The *prognosis* has been an interesting point.

When the case came in, one seemed justified in giving the mother the ordinary favourable prognosis, but the onset of the head symptoms gave it a far more serious aspect. In fact, about the fourth week it really seemed that patient was lapsing into a condition of chronic imbecility, and arrangements were going to be made for removing her to an asylum or infirmary. Dr. Goodhart, however, on seeing her a little later, was more sanguine, and gave it as his opinion that as the choreic movements disappeared, as they would do by the eighth or ninth week, in the course of an ordinary chorea, so the mental symptoms would entirely clear up. Events have, so far, tended to justify his prediction.

A Rare Case of Diabetes Mellitus.

"Among 1,360 private patients who came under Dr. Pavy, diabetes began under ten years old in eight."—*Fagge's Medicine.*

John S., a little boy of six years of age, came into John ward, under Dr. Taylor, in October last year. In the previous July he was in perfect health, and was described by his mother as a strong-looking boy. Towards the end of the summer he became considerably thinner, and later on in the autumn his mother noticed that he passed clear urine in large quantity, and often voided it irrespective of circumstances. He was very drowsy during the day, and his rest of a night was disturbed. A medical man was consulted, and the diagnosis of "drinking diabetes" made. When admitted the child was old-looking, feeble

and emaciated. The chest, except for a lateral spinal curvature, offered no mark for special comment. His lips were very red, and his tongue moist and beefy. He suffered much from thirst and had a large appetite. The urine was of specific gravity 1017, with sugar 10 parts per 1000. About ten days after admission his left apex became dull, and phthisis subsequently became evident in the left lung.

As regards urine, the quantity has always been large (the largest amount being 110 ounces per twenty-four hours), the specific gravity being low, usually 1010. The sugar dropped under treatment from the 306 grains per twenty-four hours on admission, to 224 grains ten days later. Early in December the quantity was reduced to a mere trace, went up again slightly, and disappeared altogether in the middle of that month. On 3rd January the sugar reappeared, reached a maximum of 250 grains per diem on the 10th, and again disappeared on the 17th. On the 20th a trace was found, which, under an experimental diet, increased considerably, but on 5th February dropped away to a trace, and again disappeared; came back a few days after in small quantity and again vanished on the 23rd. Up to the present the urine has remained free from sugar, but the polyuria persists.

In spite of the phthisis, coupled with the diabetes, the child, although so young, has in no way gone downhill. He is cheerful and has gained somewhat in weight (on admission 24 lbs. 1 oz., present weight 26 lbs. 5 oz.) since he came in, although he remains fearfully emaciated. He is at times drowsy, but sleeps well, eats well, and seems quite happy, taking a lively interest in all around him.

Dr. Hale White described the case to us as doubly interesting, inasmuch as the child is so young for the disease; and, secondly, that he has done so well under treatment. In these rare cases of young children getting diabetes they live usually but a few weeks.

Dr. Goodhart has seen one case of diabetes in a baby; otherwise he has never met with so young a case as the one now in John. He is inclined to consider our case as one allied to diabetes insipidus, taking into consideration the small quantity of sugar and the polyuria.

The child has been taking the usual diabetic diet, and has further been regularly treated with Pil. Codeine Co. and Mist. Ol. Morrh. *cum* Ferro.

Miriam 31. E. M., æt. 12. Admitted for pneumonia. (Query pericarditis with effusion.) Patient was in Miriam from September 13th to October 17th of last year, for acute rheumatism with pericarditis.

Patient was quite well up to February 1st; on that day she was suddenly taken ill with pain in the knees, which was so severe that she had to be carried home. The pain shortly afterwards left her knees, and attacked the left side of her chest. Patient was brought up to Guy's and admitted on February 7th, with temperature 103, respiration 40, pulse feeble and small 128. The physical signs obviously pointed to pneumonia at the left base. In addition, the dulness extended in front of the left chest up to the second rib above, and to the left towards the left shoulder. On mapping this dulness out on the chest, it revealed itself as a conical area, not stretching at all over the left border of the sternum, but with its central axis pointing somewhat upwards, and to the left shoulder. Over this dull area no breath sounds or râles could be heard. Owing to the above signs the writer and others considered the case as one of pneumonia complicated by pericardial effusion. Against this view Dr. Hale White gave the following:—

1. If the dulness in front of the left chest was due to pericardial effusion it ought to have reached the left clavicle, when so extensive as to reach near the left shoulder. At any rate, the dulness ought to have overlapped the left border of the sternum, *i.e.*, the direction of the fluid should follow the course of the great vessels.

2. The dulness in the first twenty-four hours diminished considerably. Together with this diminution of the dulness, the breath sounds could afterwards be heard over this formerly dull area. This, Dr. Hale White pointed out, was probably due to a piece of collapsed lung, so common in the pneumonic process of consolidation, and not to pericardial effusion.

3. That the sudden crisis was against the pericarditis accompanying the pneumonia.

4. Dr. Hale White considered the triple sound to be a pleuro-pericardial rub.

An interesting clinical fact on which Dr. Hale White laid much stress was that pneumonia is not a complication of rheumatic fever, but that the above case was an excellent example of how in rheumatic subjects who contract an acute illness they are immediately liable to a return of their rheumatic pains, the acute illness apparently lighting up the rheumatic process.

An interesting pathological point not exemplified by this case was also taught us, that when meningitis occurs as a complication of pneumonia, the meningitis was probably directly set up by the pneumococci, for they have been found in the meninges, in the same manner as the pneumococci set up the pleurisy in the pleuro-pneumonias; likewise in pneumonia complicated by malignant endocarditis, pneumococci have been found in the vegetations on the valves of the heart, and do apparently set up the endocarditis. They have also been found in the pus of both pneumonic pericarditis and pneumonic empyæma.

Since then, patient has been gradually improving, but only recently the physical signs have commenced to clear up, although it is over a month since the onset of the illness.

Dr. Goodhart impressed upon his hearers the importance of remembering that the pneumonic consolidation does not always clear up rapidly, especially if the pneumonic lung is pressed upon by any cause, such as by fluid, pleuritic or pericardial, or even by an enlarged heart. In this case the pressure is probably due to an enlarged heart with an adherent pericardium; also that the pneumonic process often extends even after the temperature has fallen: this was shewn in the above case as well as by others at present in Clinical. Another clinical fact pointed out to us by Dr. Goodhart, but not

exemplified by the above case, was that the cerebral poisoning in pneumonia was often most severe, especially in children, the disease being heralded by delirium and convulsions, frequently occurring before the appearance of any other physical signs of pneumonia, the condition being very hard to diagnose from meningitis.

Do not be too sure when the temperature falls in pneumonia that the crisis has occurred, for frequently the temperature goes up again and remains up for several days. The prognosis is often worse when this occurs.

In pleurisy, and in pneumonia with pleurisy, patients often come up complaining of pain in the abdomen. This fact recalls to the writer's memory that when he was on the surgical side, two patients came up to the surgery, giving a history of a previous injury to the abdomen a day or two previous, and were admitted into the Hospital for supposed peritonitis—at any rate some severe internal injury. Both cases developed pneumonia in the wards. Since then I have seen three other cases exemplifying this important fact.

M. P., æt. 66, engine-coaler. Patient admitted into John, February 27th, for very severe pain about the knee-, hip-, elbow-, and shoulder-joints. The knees were swollen, of a pink hue, and very tender; the right patella floated; the pain about the other joints was more diffuse and less extreme. There was some pyrexia.

Patient being unable to move his limbs because of the pain, "acute paraplegia" had been diagnosed. A similar mistake is not infrequent (*vide* Fagge).

The history of this attack dated back three weeks, when he felt ill and had pains in the back; the next week he became suddenly worse with pains in the limbs also. Before this no history of anything approaching rheumatism or chorea can be obtained. The case was therefore diagnosed as "first attack of acute rheumatism." Dr. Goodhart, however, said that he was very suspicious of first attacks in old people being rheumatic, and considered that these cases are generally due to a gouty condition of things.

Salicylate treatment appeared to have very good effect. After thirty hours of this (gr. xx., 3tis. horis.) he became slightly delirious; this was thought to be due to salicylism, but Dr. Goodhart observed that old people were very likely to become delirious when even slightly ill; also that this condition was much more serious than in younger patients.

Appointments.

Edwards, B., L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Medical Officer to the Ipswich District of the Samford Union.

Hall, F. W., M.D. Lond., M.S., L.R.C.P., M.R.C.S., has been appointed Examiner in Pharmaceutical Chemistry and Dispensing to the Sydney (New South Wales) Technical College.

Nevins, J. Ernest, M.B. Lond., M.R.C.S., has been appointed Honorary District Medical Officer to the Ladies' Lying-In Charity of Liverpool, *vice* W. G. Moore, resigned.

Sulphur Treatment.

F. J. S., in your issue of the 24th ult., gave a case treated by sulphur. The procedure was complicated, and could only be carried out at a hospital. I have seen similar cases do well with chloride of zinc ℈i.–℈ii. to ʒi. (Campbell de Morgan) applied on tow saturated with it, bound up, and left for three days. I believe that sulphur taken internally is most useful, and might with advantage be often given previous to operation. The sulphide is supposed to be a specific for boils. Dr. Clay said sulphur and Chian turpentine were specifics for cancer, and Garrod says it is the best liver stimulant in gouty conditions. Tincture perchloride of iron acts magically when given internally in some cases of erysipelas, and other acute affections of throat, lungs, etc. I remember, many years ago, Mr. Cock treating an ulcer by applying nitric acid, etc., without benefit, but directly he gave perchloride of mercury, healthy healing commenced. Arsenic I believe is much neglected. Malaria used to be very common in London, and no doubt many patients now suffer from mild doses of the poison, but it is unrecognized. Skin affections are mostly treated by local applications, but many would yield sooner, I think, by attacking them in every possible way. I even think that Isolation Hospitals are scarcely needed, for if arsenic and iron were given to all susceptible ones in the vicinity of epidemic diseases, as scarlet fever, diphtheria, etc., they would be protected as a garden path is protected from weeds, by using arsenic.

We know the symptoms of scurvy, but do we know the symptoms when the system is only suffering slightly? What would be the effect if each patient at Guy's had to take one orange or its equivalent daily? Would there be more cures in each 1,000 hours.

Since we are now engaged in fighting germs, or at least trying to keep them in their proper places, does any hospital authority dream of what the air of a ward must be in the morning, at the time the nurses are shaking the blankets, making beds and dusting. Each ward needs a verandah where this shaking of blankets might take place, and where patients could bask in the sun; though we have diplomas for Public Health, yet we put patients where they can get no sun. About a year back, in the Gazette, was related the case of a poor Guy's student who was a patient off and on for two years; perhaps the termination might have been different had he basked in the sun?

I will add a few remarks on points which have served me well, and may be suggestive to others. For capillary hæmorrhage, when operating on inflamed parts, don't attempt to tie more than the one or two main arteries, then apply tow saturated with chloride zinc lotion, bind, elevate and apply gentle pressure for some time; after three days dress and bring parts together. For hæmorrhage, especially from wound or ulcer of hand or foot, a triangular-pointed needle will often succeed by pressure,

or a plug with turpentine, or alum, or iron; but the best and most powerful styptic for obstinate cases is fluid chloralum.

The following application I have found most useful, applied near or some distance off, either in preventing inflammation, or helping to subdue if present. In numberless cases of injury or disease, it has taken the place of iodine with me:

℞ Liq. Ferri Perchlor. Fort. ...	...	1 part.
Ol. Terebinth	...	1 „
Acid Carbolic	...	1 „
Glycerine	...	2 „

And I believe in rubbing the spine with oil sometimes, with a stimulant added—it helps to bring back a vitality that will assist convalescence. The Japanese employ blind people as masseuses, perhaps we might with advantage follow their example.

T. H.

Izal.

During a research made by Mr. J. H. Worrall, F.C.S., F.I.C., Chemist to the Thorncliffe Collieries, near Sheffield, into the nature and uses of a certain unknown oil derived from the Thorncliffe Patent Coke Ovens, a body was extracted which possessed high antiseptic properties. Its antiseptic power, estimated by observing the length of time required to arrest the putrefaction of a putrifying liquid, is considerably greater than that of carbolic acid. The product, after undergoing a process of refinement, is a clear deep reddish-brown liquid, insoluble in and of greater density than water. Its boiling point is considerably higher than that of pure carbolic acid, it has no caustic action upon the skin, and is non-poisonous to the higher animal life.

Izal is a perfect milk-white emulsion of this new antiseptic agent. It is miscible with water in all proportions without any separation occurring.

The property which above all recommends itself for consideration in the application of a disinfectant to disinfecting purposes generally, and especially with regard to infectious diseases, is that of persistency. In this respect Izal is pre-eminent, this being due to the fact that the actual constituent of the disinfectant has a boiling point exceeding 400 F.

Dr. E. Klein, St. Bartholomew's Hospital, has made an elaborate series of experiments upon Izal with the view of ascertaining to what degree the emulsion is capable of killing, *i.e.*, disinfecting pathogenic and non-pathogenic microbes, and also in what proportion it is capable of inhibiting the growth of those microbes, other conditions (mediam and temperature) remaining favourable.

The result of these experiments shows that Izal possesses great disinfecting and inhibitory powers, which compare favourably with other well known antiseptics.

There can be no doubt that Izal will secure a high place among our already extended list of disinfectants and antiseptics.

How should we study Medicine?

The Lecture Introductory to Session 1868-9, at Guy's Hospital.

By WALTER MOXON, M.D.,

Fellow of the Royal College of Physicians.

(Concluded.)

Don't be dazzled by brilliant aims. Keep your minds fixed on to-day's duty, for our life is not lived to an aim. *Sine missione nascimur*, we live to a duty. Don't let us think and act as if we were here to sweep disease and death off the face of the earth, or to give life for half-a-crown a bottle. This is rather our humbler, yet our truly nobler service—it is, to be to each individual sufferer under our care all that a man can be to his fellow-man in sickness.

Publicly in our writings, and privately in our thoughts and acts, let us keep to the duty of truthful observation; training our reason until it becomes an instinct with us to see what is actually correct, as other men's consciences are trained to feel what is morally wrong, until we acquire a *sensitive reason-conscience*. Let us do away those volatile aims at cure; they are our greatest enemies; they ruin our social reputation. For why is it, if we are only honoured in the sick room, or, as the old saw has it—

"God and the Doctor they alike adore,
Just in the hour of danger, and no more;
The danger o'er, both are alike requited;
God is forgotten, and the doctor slighted."

There is much plain truth in both sides of that old comparison. I am not one of those who so easily put themselves in the place of the Divine being, and speak for Him. But on our own side, let us see if it is at all our own fault. It is not, in great part, because we keep before people the aim of cure when we deal with the sick? Do we not allow them and their friends to assume that we heal, and so get credit that does not belong to us, so long as their minds are shaken by disease or anxiety? But the public is not always sick, and when it comes to itself, it has its own opinion about the cause of recovery, and despises those who for profit, or through pre-occupied foolishness, favoured the thought that the work of Nature was their own work. Just as when the daylight gave them courage, the enlightened public drowned those very witches whom they shuddered in awe of in the dusk. You need not fear being forsaken. 'Tis not hope that sweetly leads a man to his doctor; 'tis dread that drives him to you. There is so much contentment in human nature, that it is governed more by fear of change than by expectation of advantage. The ancients went to their oracles, though the oracles did not help, but only directed them, and that often ambiguously. And people frequent lawyers, although no lawyer can make your claim to another person's property any stronger than it is. But do you watch your cases carefully. Guide according to convictions whose

grounds you yourself know. Be very kind to your patients, and don't hurt them, and give Nature her full credit.

But that you may be able to do this—for a long life of duty will leave you very imperfect in it—pray be now convinced that you must begin a course of self-reliance from the first, identifying your intelligence with the principles of the knowledge you gain. And begin this course at once, for you live at a very critical time in the history of our profession. The medical world is full of the professors of fragments of knowledge, who don't understand each other. We live at a crisis when the art is so long, that it is dividing up spontaneously, like some worms and other low beings do when mass exceeds organization.

Get an independent, well-grounded familiarity with diseases for yourself, or you will never escape from the crowd of experts that will thrust their help upon you, to aid you with all sorts of —graphs, and —scopes, and —ometers. They will importune you—these multitudes of guides—to start on the old labyrinth from their new start-point, and to follow their thread, which will put you at their mercy; but do you start from some ground you know yourself, and take your own thread. Use the new-fashioned instruments rather to guide and educate your old and trusty five senses than to replace them. Your senses you have always with you. No one can carry all the modern medical machinery. Let the thermometer teach the hand, the microscope quicken the naked eye, until the instruments can be put aside, as Reason puts aside logical forms. Do you remember the oldest whisper out of ages that comes from the great Father of Medicine, "Life is short." With good reason he throws across to you first that curt sentence of a truth that is "ever unperceived, never understood." There is no time to waste; the art has grown longer since he said it was long, but life is as short as ever. And not merely has the art grown long; it has outgrown the reach of common industry, and hence a crisis. Gentlemen, I say that when the mass of knowledge in any craft or profession grows larger than the capacity of its individual followers, then there is a crisis, and only one thing can save it from revolution and overthrow; and this thing is, that sound general laws must be discovered, which, at the time when the craft so extends beyond the capacity of its individual members, shall give power to them to know in principle what they cannot follow in detail, that in these principles they may have established common ground, where they may meet and understand each other, and control each other for the common good. And the subdivision of the craft must be in accordance with such principles. But when, as now, one doctor says, or allows it to be said for him, "I am for the nervous system," and another, "I for the chest," and another, "I for the liver and digestive organs," what principle is there in that division? And when another pair of doctors say, "We are for this common disease, 'as exemplified in private practice,'" what principle is there in that division?

Gentlemen, let us see how grave a thing it is that our profession is divided; and let us see to the principles of division, if it must divide, or, if there are no principles, then let us prevent men from cutting it up; and then, like X, Y, Z, and Ampussy And, all running off with a piece in their hand, and the richest and most "private practice" piece they can get hold of.

Let us remember the Tower of Babel, and keep down ambitious and futile and empty aims, and look to our agreement in a possible work, lest we cease to understand each other, and break up in confusion. Already the nerve-doctors, and others of these cross divided patches of physic, puff complicated remedies, whose efficacy no one can possibly know. Let us keep together, and keep to strict observation and proof, or we shall go back to Mediævalism, to a sort of Medical-Ritualism, to a Medication by Faith.

None can help us but our own individual resolutions, blended into a strong mutual will. Let us take only what we can grasp, and take it firmly from the facts of Nature, for we each must be ready to face the duty of dealing with any disease at any moment. Learn well the action of as many remedies as you know to be truly useful. You go forth to do battle as with all sorts of terrible wild nations and beasts of diseases, whose weapons and mode of fighting you indifferently know. And your Alma Mater will offer you an old Tower of London sort of armoury, nearly all odd things, grotesquely out of date, in what is called a "Pharmacopœia" of more things than any man can know the use of. But do you choose such weapons as you can handle, even if they but as five smooth stones from the brook, if those are all you can handle well. He is not the best soldier who carries the largest collection of war-like implements, but he that wields his weapon best.

We shall try to make you a *vir doctissimus, et ornatissimus, et clarissimus;* but pray, while you are getting all the newest fashionable learning of our time, remember that the newest patent clarified stearic candles may give no better light than a well-managed common dip. And you are called to the bedside, not to be admired, but to help. You live to do a duty of patient investigation and guidance. Not that we should neglect to cultivate ourselves; for though, as men occupied in the same direct duty, we shall be like instruments playing the same tune, yet remember the same tune sounds very different on different instruments. And while we keep ourselves sternly to observe and know the facts of disease more and more, we must not neglect to avail ourselves of every means of self-development, and of accomplishment; for a chief pride of our noble calling is, that in it there is direct use for every grace of mind and of body. We have to be, as it were, resting harbours, where the broken minds of the sick may refit with every mental strength; and we must be ready to give aid to each shaken faculty; we must be ready to create faith—that greatest of tonics—for the unbelieving, and hope—that best of stimulants—for the despairing; we must find

fresh interest for the weary of life, and not merely know a few things which others are ignorant of.

Now, if you will bear this simple view of duty in mind, it will greatly aid you to success in life, which we all wish you. We have often seen the ill-effect produced by the bumptious conduct of a medical man, who was up in the air, above his first simple duty of carefully ascertaining the actual state of his patient, behaving as if all his duty was to send the curative potion he had learnt, directly or indirectly, from some "Theorist," as if he knew the case without examining, when he really did not, and when sensible patients know well that he does not, and cannot, know.

I am sure the most experienced of us will support me, when I say that the more you carry out your real and natural duty of observer and guide, and the more you keep away from aims at cure, the more you will be liked by the better class of patients, because you will conform better to their instinctive knowledge of human reason, the kind of thing it is, and its limits of action; and the more you put forward pretensions of cure, the more you are likely to suit only very low, and servile, and ill-educated, and, therefore, probably poor people.

If you learn your profession well and soundly, and practice it honestly and frankly, giving Nature her due credit, you are sure to get a good living. We cannot promise you a great success in life; but we can promise you more—To deserve it. We must all be ready to see others get on better than ourselves without envy. Money price is paid for social value; and the social value of a doctor is not only his knowledge and skill in his art proper, but it is also his adaptability to the complex and varying nature of the people he comes in contact with. Some of us are not such pleasing people as others, and such of us are apt to complain that practice is not distributed according to merit, all the while, of course, thinking of ourselves; which is very foolish, if only because such thoughts sadden and sour us, and so make us less nice than we were before. But if we see, first, the simple truth that money price is paid for social value, which much depends on points of nature and points of fortune that are all out of our control; and, next, this other simple truth, that there is also individual merit, of a private sort, that we all may possess, though we won't be paid for it in cash, and which nothing can deprive us of, *Quod non dedit fortuna, non eripit*, we shall gain this advantage, that we shall be able to congratulate others on their greater success, and yet not feel ourselves degraded.

The man who takes 12,000 guineas a year, and despises them all, living only to duty, is not disloyal to the nobility of his profession, as the man is, who grumbles over his 500, and forgets that he all the while is doing what is above money, and without price. Murmuring that the labourer is worthy to get his hire, and forgetting that the hire is not worthy to occupy the labourer.

For a doctor no more lives to get money than a Lord Chancellor for his £5,000 a year, or than a gentleman lives to wear fine clothes. In each case these are casually prominent incidents.

The only worthy obstacles to self-abnegation are the wife and family; but even then, if by any reflections you can reach contentment, you shall not get less, but by thinking less of self, you shall become more pleasing, and so get more.

We don't want you to be over-philosophic. 'Tis true, philosophy is the ripeness of human intellect; but then remember ripeness is only the stage before rottenness, and that the world will always be governed by the youngest, juiciest, and most active minds that are in it. Hers, too, is a kingdom that is taken by force. When young men under thirty take to philosophic and pensive reflections, instead of striving with might and main to get all the honour and wealth they can fairly achieve, then they are like those apples that you see turn red on the trees before ripening time; and you need not look closer at those apples, you know there is a maggot in them.

If you are in for the London University or for the Hospital prizes, don't let another man pass you without pulling your best. Sometimes you hear life compared to a down-stream into an ocean. It is a good old simile, but, like many others, it is better the other way about. We come out of Eternity, and pull up the stream; and nowadays, while we are young, we have lots of water and elbow-room; though sad are the risks that sometimes sink the best, and bravest, and noblest of us, in spite of personal strength and every lovable quality.* But as we move along, the banks are coming nearer, and so is the bottom, till after a few sharp rubs we get aground. Such is the natural course of your life. For if, as I have shown you, Learning is rather a development than a progress, Life is rather a progress than a development. By the law of nature—inexorably—you must leave the years as they go, and be limited to those that are to come. But if you are loyal to your noble profession, and follow in all your doings heroic truth and duty, then, as what is to come grows narrower, what is present grows wider about you; and instead of a future, you shall live a larger life, until present and future blend, and are one and the same.

* George Rootes, the son of Dr. Symonds Rootes, of Ross, Hereford, was appointed house-surgeon to the Hospital on the 1st of September 1868. In about a week he took diphtheria, apparently from a patient whom he attended in the surgery, and, after an illness which he bore patiently and bravely, died on Sunday, September 26th. The words in the text but feebly describe his character and person; for he was so handsome and generous, and so remarkably gifted with readiness of speech, and with kindness of heart, that his death cast a painful gloom over the whole School and Hospital, in which he was much beloved.

APPENDIX.

As, in answer to a general desire on the part of those who heard this lecture to have an opportunity of perusing it at leisure, the lecturer is constrained to print it, he must beg permission to guard it by one or two remarks.

An impression was left by it on some minds, that the lecturer had inferred that there is little to be done for the sick, and that the attainable knowledge of diseases is, at best, loose and unsatisfactory. He is sure that the reading of it over will remove that impression. What he wished to urge was this: First that any knowledge of diseases which is communicable from one to another is vague and remote, and not directly applicable in our every-day duty, and that its best use is merely to give names by which we can remember, and indicate to others what we ourselves see; and, second, that any one can for himself get a most valuable knowledge of and power over diseases, by directly, and closely, and carefully watching the conditions and courses of those cases of disease that come under his own observation.

He wished to urge to the attainment of such a practical knowledge of, or rather familiarity with, diseases, regarding it as of the utmost value, of incalculable value; without it there could not be that security for individual life which is the foundation of society. If he said comparatively little in commendation of the aids that will be given to the student in every branch of study, this was from confidence that the help given by each of his able colleagues will fully commend itself in good time. What was spoken against the study of medicine through the medium of books is over-general, and has a more sweeping effect than it would have had if time had permitted the lecturer to draw a just distinction between those several excellent works, on the one hand, in which the facts of disease are clearly and fairly stated as far as possible, and the conclusions and suggestions that naturally arise from those facts are put and considered in a judicial and impartial spirit; and, on the other hand, those works which periodically make their appearance in which some theory or another is thrust into prominence, and obstinately held there in curious and, to him, inexplicable disregard of its triviality, and the utter absence of any support that can be compared with the confidence and vigour with which it is put forth again and again.

Lastly, the limits of time, likewise, prevented the lecturer from describing, at greater length, that power over diseases which is sure to be attained by any one who perseveres rightly in the search of it, and is determined, on the one hand, to let nothing, through his negligence, escape his notice, and, on the other hand, to cautiously yet boldly allow himself, in due time, to be certain as to the courses of the diseases he watches, and as to the degree in which his measures have modified those courses.

No one can watch the practice in great hospitals, in a liberal and candid spirit, without perceiving that the public view of the usefulness of the medical and surgical art is more than justified by the results obtained in its practice. We do not do impossibilities, and failure is too apt to produce an over depressing effect on the minds of those who come into our profession with an over-sanguine a view of their future usefulness. That depressing impression is, however, removed gradually when we come to perceive, first, how absolute and how intimate is the necessity which compels the sick and their friends to seek whatever aid they can obtain at the hands of their fellow-men, and, secondly, of what real and direct value are the guidance and management, and certainly also the remedial agents, which a competent medical man—a true physician, an observer of nature—is able to bring to bear. In the long run he comes to feel, and I believe justly, that society is his debtor, but if he follows his calling in a worthy spirit, he can turn from the comparatively poor social rewards that he gets for his labour, to the sense of a high duty discharged with the best of his ability, which is a reward, that though it goes for little in print or speech, not being able to be uttered, except when counterfeit, yet no one who is not a pitiful and inhuman wretch can at heart despise it.

Physical Society.

We have managed to get behindhand with our reports of the Physical. Three excellent Papers have, so far, received no notice in the Gazette. Of the first of these, Mr. Steward's paper, we shall publish an instalment in our next. It was read on January 20th, and evoked a lively discussion in which both physiology and the practice of Physical Exercise were dealt with by speakers evidently keenly interested in one side or other of the subject. It was to be noted, however, that none of our most prominent athletes were to be drawn out of their wonted silence, even though the greatly interesting subject of "second wind" came on the tapis.

A paper by Mr. J. B. Parfitt on the "Decadence of Teeth" attracted an audience of fifty members, and was greatly appreciated. The fact that the Dental Students took so small a share in the debate which followed has led, as our readers will have noticed, to some correspondence in our columns. Whatever may be done with regard to the formation of a special Odontological Society at Guy's, we hope that the Physical Society itself may profit more in the future from the counsels of our Dental colleagues.

They are accustomed, of course, to seeing other people's mouths open while their own are shut, but they should break through the rule on occasions like this.

On March 3rd, Mr. E. A. Peters read a very learned and exhaustive paper on "Immunity." Forty-five members were present, and though only the odd five managed to get on their legs for the purpose of discussion, several interesting points were made, and the debate would doubtless have continued but for the lateness of the hour.

The present session of the Physical has been undoubtedly a successful one, both as regards the quality of the papers read and also with respect to attendance of members, which has averaged forty-three.

Passim.

All our readers will have heard, with profound regret, of the sad death of Mrs. Washbourn. When we last went to press hope was felt everywhere that she would recover, for she had then rallied from the dangerous condition present during the previous week. When, therefore, the end came a few days later, the universal sorrow felt at Guy's was but the deeper for these temporary hopes. Dr. Washbourn, and the relatives of the deceased, have at least the consolation of knowing that everything was done that human skill could divine to avert the terrible scourge which was the cause of the sad occurrence. It developed, as so often happens, in spite of every precaution that it was possible to adopt.

On the occasion of the funeral, four wreaths were sent from Guy's in the name of the Students, and Dr. Washbourn wishes us to express here his deep sense of the kindness thus displayed, and his great appreciation of the sympathetic feeling among Guy's men which the act betokened.

It is rumoured that a Guy's Dental Society is on the way to be instituted, in accordance with suggestions made in our correspondence column. We have been inclined to view the proposal with some mistrust, because anything like the formation of fresh cliques is so very undesirable; but the arguments in the letters published to-day are not without cogency.

A correspondent writes to us complaining that our ward column has hitherto neglected the cases in Clinical. It will be seen that to-day Miriam and John monopolise the column. We heartily apologise to those gentlemen who have sent us cases from the other wards for not inserting the same on the present occasion. We purpose to communicating with them privately.

The Debating Society meets to-night. Mr. Ham will move that the present tactics of the Teetotal Party encourage the vice of Drunkenness. Mr. H. T. Harris, M.B., will reply.

Gentlemen intending to present themselves for the Final Conjoint Examination in April next, are reminded that they should obtain a schedule and get the vaccination certificate signed on, and leave it at the Medical Office not later than March 17th.

The Association Semi-final Tie v. University will, in all probability, be played on Tuesday, March 13th, at Leyton. Trains and any alteration in the date will be posted up in the Club. On the following Saturday the team will have to fight out the Final Tie for the possession of the Surrey Senior Cup with Reigate Priory, at Guildford. We hope that we shall on both occasions be well supported by Guy's men.

We feel sure that the scientific and brilliant displays recently given by the Association XI. deserve a larger audience of supporters than has of late years been their lot. The Inter-Hospital Cup is the one which we especially desire to see adorning the Smoking Room, after an absence of six years. We should be sorry were we to lose it through lack of partisans to cheer our men on throughout the struggle, after our brilliant victories over Mary's and Bart's.

The friends of Weybridge are evidently highly disgusted with their champions' downfall, for we see that three attempts have been made to find some ground for our disqualification, or a replayal of the match. First they appealed against the ground, but, unfortunately for them, not within the time stated in the Surrey Football Association rules; then they wired and took other trouble to find out whether one of our players had put in a necessary number of

appearances in the team this season; and, thirdly, they protested against the encroachment by the spectators on the field of play—a circumstance, if we remember rightly, which caused them little inconvenience at the time, as all the attempts to keep the crowd back were made by members of our team.

When we lost the Rugby Cup last year we retired with honour, and defeat was sweetened by the knowledge that our team had shewn up so excellently well. We wish heartily that the same feeling might have lightened our trouble this year; but it certainly did not. It is strange that anything in the way of previous dissension should affect the play of a team with such fatal results; but it was evident, down at Richmond, that the poor show we made was due, not to the actual constitution of the team (whatever the critics may say), but rather to the psychological effects engendered by previous dissension. We do not suppose any individual player will admit this as regards his own efforts, but to the onlooker it was obvious.

As to the constitution of the team, individual opinions must differ, and it must be understood that the report which appears in another column is written from the point of view of an individual opinion. But we are bound to claim that our reporter has the majority with him. From much correspondence on the subject we select one letter because it comes from the very highest authority and at the same time embodies the views of the rest. But our correspondent is not quite well informed upon one point. He writes as though the sole merit of the player who occupied the disputed place in the team was that of having played "regularly." On the contrary, he has all along done yeoman's service for Guy's; but the point in dispute is simply whether he was in a fit condition to play on this particular occasion.

It cannot be denied that the general principle which led the committee to exclude a player whose interests are not whole-heartedly with Guy's is a sound one; but it is a good thing to recognise that all general principles have their limits in application.

It would be just as well, however, if everyone were frankly to acknowledge that the best team won, and that in any case we should have lost. We congratulate Thomas's on last Thursday's victory, which gave them the Cup once more.

At the recent Inter-Hospital Cross Country Competition we secured the first four places, Munro being first, C. D. Edwards, P. F. Henry, and H. W. Dudgeon following in order named, thus securing the Cup for the third time. King's were second, beating Mary's by one point.

Arthur Edward Durham, March, 1894.

How we shall miss him! Who that ever knew
His kindly greetings in the colonnade
Will e'er forget his handgrip? And who
His manly counsels and his generous aid?
And from whose memory will ever fade
The tall gaunt figure and the clear blue eye
Which took at once the smallest detail in,
Who watched the tapering fingers deftly ply—
An active index of the mind within?
We know the many-changing light and shade
Of his too generous nature, and we know
He feels for us as we have felt for him
In joys and sorrows; and our eyes are dim
As we do cry, "God bless him!" ere he go.

Acknowledgments.

Congenital Affections of the Heart. G. Carpenter, M.D. (London: John Bale & Sons.)

Elements of Bacteriology. Dr. S. L. Schenk. Translated from the German by W. R. Dawson, M.D. Illustrated. (Longmans & Co.)

Manual of Practical Anatomy. D. J. Cunningham. Vol. II. (London: Young & Pentland.)

The Cambridge Review.

The Hospital.

Marriage of Dr. Pye-Smith.

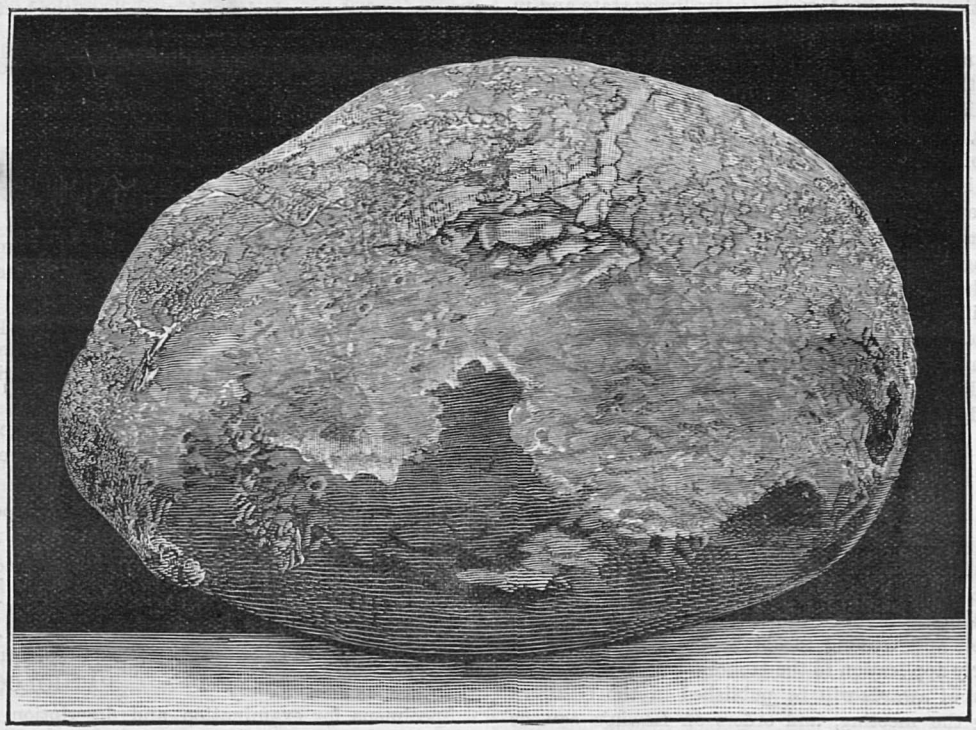
On Wednesday, March 7th, at one o'clock, the marriage of our Senior Physician, Philip Henry Pye-Smith, M.D., F.R.S., with Emily Gertrude, youngest daughter of the late Arthur Foulger, of Chigwell Row, took place at Christ Church, Lancaster Gate. The ceremony was performed by the Vicar (the Rev. C. T. Ridgeway), assisted by the Rev. Professor Sanday, D.D., an old friend of the bridegroom. It was a beautiful day, and the large church was nearly filled by the friends of the happy pair (and very happy they both looked). The bride was given away by her brother, Mr. Howson Foulger, and there were present all her brothers and sisters, the bridegroom's mother and all his brothers and sisters, and numerous family and other friends, who, after the ceremony, assembled at the house of the bride, where refreshments were served, and the numerous and handsome wedding presents were inspected and admired. Among these we noticed several from members of the Staff, and a very pretty silver tea-kettle from the Students. The bride and bridegroom left for Exeter in the afternoon, *en route* for Italy.

Calendar of Coming Events.

Mar. 10th.—1st XV. v. Richmond, at Richmond.
2nd XV. v. Sidcup 1st XV., at Honor Oak.
2nd XI. v. Anerley, at Honor Oak Park.
Guy's Hospital Debating Society. Meeting.
„ 13th.—Schedules for the Final Conjoint Examination to be left at the Medical Office, not later than this date.
1st. XI. v. University College Hospital. Semi-final, Inter-Hospital Association Cup.
„ 14th.—Examination for Arthur Durham Dissection Prizes.
„ 15th.—Medical Prayer Union. Rev. C. H. Bowden. A Devotional Address. "Praying in the name of Jesus." St. John xvi., 23.
„ 17th.—2nd XV. v. Brockley 1st XV., at Brockley.
1st XI. v. Reigate Priory, at Guildford. Final of Surrey Cup.
2nd XI. v. Old Wilsonians, at Honor Oak Park.
Physical Society Meeting. Treasurer's Prize Essay, "Pathogenesis of Mordid Growths."
„ 19th.—Examination for Michael Harris and Beaney Prizes.
„ 21st.—Lectures Cease.

Calculus removed by Mr. Davies-Colley, February 1st, 1894.

Case of H. H., Luke ward.—Actual Size.



GUY'S HOSPITAL LIBRARY

In our issue of February 10th, page 48, a case is described in which a calculus was removed by supra pubic incision from the bladder of a man, æt. 30. The above engraving is from a photograph, and gives the actual size of the stone; it weighed sixteen ounces.

Extracts from my Note-Book.

By THOMAS BRYANT, F.R.C.S. Eng. and I., M.Ch.

HUNTER ON THE LIVING PRINCIPLE.

"THE changes arising in the vegetable and animal matter during the presence of life, are produced alone by the peculiar powers of the principle of life. To its operations we refer all the secretions, all the new productions, the digestion of other substances, etc., etc."

"The operations of the principle of life cannot be referred to mechanical powers."

"Life is totally distinct from any property of mechanics. We see, indeed, the movement and construction of the bones are regulated by the laws of mechanism, but the actions of the muscles which put the bones in motion are not owing to any mechanical powers or principles, nor by mechanical principles can they possibly be explained."

"From an examination and survey of animal matter when dead, we gain an idea of living animal matter, as from the living only we gain an idea of death; so from death only we form an idea of life."

"The functions and changes in an animal body during life are all to be referred to the operation of the principle of life. The property of the principle of life consists in preservation of animal matter in its living state and in action."

"Life may exist without matter being in a state of action; the property of self-germination may alone be present, life at the same time being present in full force."

"Thus, a new-laid egg is truly and really alive, though no kind of action is known to be possessed by it."

"The blood is not only alive in itself, but it also, by circulating through every part of the body, becomes the means of and carries life to other parts; thus being the living support of every part of the fabric. The nerves themselves are supported by it. They do not convey life to the parts, but only direct the motion of parts, and without the blood themselves becomes dead."

"Organisation is not necessary to life; an egg is not organised, and yet an egg is alive. So blood is not organised, yet it is possessed of life."

Notice.

THE HOSPITAL "BLUE."

THERE will shortly be a meeting of the "Blues" Committee to consider applications that have been made by past students. Any men who have not yet applied, and are eligible and wishing to obtain the "Blue," should make early application to the Honorary Secretary.

The list of awards will be published in the GAZETTE following the meeting, and orders on Lewin's can be obtained from Dr. Shaw.

H. HEWETSON,
Hon. Sec. "Blues" Committee.

In Memoriam.

WITH deep regret we have to record the death of LIONEL ALEXANDER PAUL, which occured at the Royal National Hospital, on March 1st, from phthisis.

Having been educated at a school in Winchester, he entered Guy's in October, 1891.

Those who knew him, will remember how ill he was looking last summer; but, in spite of ill health, he did not give up his Hospital work until last October, when by medical advice he decided to spend the winter in a more healthy atmosphere, and shortly afterwards went to Ventnor.

Paul was no idler, and it is to be feared that hard work, combined with successive family bereavements, served as a predisposing cause of the very acute attack to which he succumbed. His quiet and unobtrusive manner, and most unselfish disposition gained him many friends not only at this Hospital—where he has already been greatly missed –but also at the Ventnor Hospital.

His medical attendants speak in the highest terms of his patience, and the pluck with which he fought his illness; and those who knew him well are the best judges of the excellence of his character.

Had he have lived until the 15th of this month, he would have attained his majority.

From the Gazette's Special Pathologist.

W. H. M., KIDDERMINSTER.—Rapidly growing epithelioma of cervix. There is a great deal of surrounding infiltration; leucocytes are in places collected into small packs, presenting a peculiar appearance. In the deeper parts the malignant cells are much separated. The parotid tumour has a mixed stroma of fibrous and cartilage; while the glandular elements prove it to be an adeno-carcinoma.

A. R. F. E., PENZANCE.—The growth is a large round-celled sarcoma; there is considerable deposit of blood pigment.

E. W. W., HITCHIN.—Regret we have lost specimen. Kindly send another.

G. P. W., MELTON MOWBRAY.—No bacilli detected.

E. H. L., ST. ALBANS.—No bacilli detected.

E. R. M., HASTINGS.—No bacilli detected.

G. S. S., NORTHFLEET.—Tubercle bacilli present.

PATHOLOGIST.

Specimens for examination and description in this column, should be addressed to H. HUNT, GAZETTE, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

Humour of the Wards.

Dr. X., on his usual round the other day in —— ward, came to a new case. The patient was a Pole, who understood and could speak English very well, but was rather deaf. The House-Physician quietly mentioned the fact to the doctor as they approached the bed. Dr. X., in a loud voice, asked patient what he complained of. Patient made no reply. The doctor repeated the question in a louder voice. Still no reply. A clerk, noticing the unpronounceable name on card at head of the bed, suggested that the patient was a foreigner and did not understand. "Yes," said the doctor, "I observe that, and also that he is very deaf." A clerk, who had been listening at a chest at the next bed, hearing nothing of this conversation, now joined the group about the bed. He also observed the name on the card, and heard the doctor shout the question once more to the patient. The patient only muttered something to himself, whereupon the last comer said, "I think, sir, he is an Italian, and does not understand English." Everybody laughed except the doctor and the clerk. The joke was explained to the observant clerk. Just at this juncture another clerk came into the ward. Seeing the chance of some fun at the latest arrival's expense, one of his fellow clerks took him aside and whispered to him that the patient was a German, and could not understand a word the doctor was saying. He suggested to him to tell the doctor so. He did. Climax!

The other morning some patients were overheard discussing together their various diseases. "What did the doctor say was the matter with you?" asked a patient of an Irishman in the bed opposite. "Faith I dunno at all, at all," said the Hibernian, "but I think me voice musht 'ave shlipped down to my heart, for the dochtor told the students that he could hear the murmur there."

"Your temperature is very low this morning," said a clerk to his patient. "So is my diet," the latter remarked.

"Do you know what that is?" asked the lecturer of one of his class as he handed him a bottle containing a specimen resembling a somewhat large Spanish onion. Student stares hard at it, turns it round to see if there was any label on it, turns red in the face, and passes it on to the next man. Next man does ditto, and so on right down the row. No one ventures an opinion. "Surely," says the lecturer, with a bland smile, "it's perfectly obvious what it is." Moral: The "obvious" is not always the normal.

A patient who had been "tapped" several times often referred to the operation as "the last time he was 'pumped.'" One Sunday night, at the usual evening service in the ward, he was rather refractory, and frequently interrupted the sermon by calling for someone to come and attend him. The preacher took no notice of the interruptions, and was narrating a story of how some men were wrecked on a dry and arid island, with not a drop of water to drink, when he was again interrupted with the loud demand, "come and 'pump' me."

A student's list of ancient mythology—

Bacchus.
Venus.
Mercury.

"What is the best way for a man to lengthen his days?" asked the student. "Shorten his nights," replied the doctor.

Scene.—*The Lecture Theatre.* A dozen or more students asleep. Lecturer pauses, and asks someone to open the ventilators. "It's rather unhealthy for these gentlemen to sleep in a hot room," he remarked, somewhat sarcastically. B. B. H.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Inter-Hospital Football.

Sir,—The match between Guy's and St. Thomas's, before which it was commonly reported that Guy's was likely to win, must have caused considerable disappointment in its result; but among old lovers of the game a greater mortification was felt on account of the poor play shewn by our side. It is, perhaps, a little unkind to blame a set of men who have been beaten, and who, as individual members of a team, no doubt, worked their hardest; but mere hard work is not football, and this should be impressed on certain individuals, who, when in possession, preferred always to lie on the top of the ball or rush with it into the thickest part of the scrummage rather than to pass back.

Comparing last year's match with that recently played, it was generally admitted that we failed in the former game owing to the weakness of our forwards, but whilst pinned up by the St. Thomas's forwards some very admirable play was witnessed on our side behind the scrummage, and especially by a half-back who was not included in this year's team; the defence, indeed, and a brilliant run by a three-quarter, were the redeeming parts of that game; but in this year's display I saw little to admire or commend. True, the forwards were much stronger than last year, though still less powerful than St. Thomas's, and one freshman was a very decided acquisition to the team; but when it was found in the first quarter of an hour that they could not hold the St. Thomas's forwards, it was clearly our play to

keep the ball loose and give the back division a chance. Here was the great weakness of the side. Passing by the half-backs was scarcely ever attempted, or, if it were, it was a signal failure.

I do not know the captain or the members of the committee, but I think a grave responsibility rests on them for not putting the best team that the Hospital possesses into the field. Because a man has played regularly for the team is not sufficient reason for retaining him in the Cup team if a decidedly better man is available, who is prevented from playing regularly; and the selfish play which characterised our side is reflected in this arrangement of the committee. When the Hospital's reputation is at stake, there ought to be no question as to the rights of long service. Efficiency should be the only guide in selection, and men who are known to be inferior to others available should gracefully retire.

The Association team has since done its best to retrieve the reputation of the Hospital, but a similar feeling in favour of long service seems to have nearly destroyed our chance for the Association Cup in the very first round. The lucky chance which gave us a second entry enabled the committee to re-select their team with a result more than satisfactory. Had the Rugby committee a chance of re-selection, it would have been easy to see where an improvement could be made.—Yours truly,

AN OLD FOOTBALLER.

A Guy's Dental Society.

Dear Sir,—With regard to the "Deficiency of Dental Debate," I think it is undoubtedly due to the fact that we dental students have no means of becoming proficient in this particular section; and for the simple reason that we have no Dental Students' Society. I must confess that I was surprised when I came to Guy's to find none in existence; and, on asking, was told that there was no need for one, because we had the "Physical Society."

Now, with regard to that undoubtedly good Debating Institution, I venture to say that there are many of us who would willingly make an attempt at speaking in public if we had a society as Mr. Hopson suggests; but where is the man who cares to make his first attempt before others—who are accustomed to hear the sound of their own voices in public—with a possible failure?

No, sir, what we want is a "Dental Students' Society."

The schools of the London Dental and National Dental Hospitals have their Students' Societies, and why should a flourishing school like ours be without one?

As Mr. Hopson suggests, we should be better off than the schools I have mentioned, because we should have the advantage of our medical colleagues on subjects on the borderland of dental and general surgery; for, sir, I would suggest the first rule of the new society be "That every candidate be a member of the Physical Society."

Again, it would be the means of keeping past and present students in touch; and at present we have no such opportunities. I cannot see where the objections to the formation of the above society come in. Perhaps we shall be enlightened on some.

Thanking you for your valuable space,—I am, yours sincerely,

March 1st, 1894. "PLAIN SPEAKER."

Dear Sir,—Having seen the letter of Mr. Hopson in your last issue, I feel it my duty as a dental student to write a few lines on the subject of his letter (the formation of a Dental Students' Society). Surely no one on reflection can have any objection to it, for as we stand now we feel we have not sufficient opportunity for the discussion, *en masse*, of dental subjects; but if a Dental Society were formed, we should be able to discuss these subjects as our Physical Society does medical subjects. As dental students of Guy's Hospital, we naturally should hold a position equal to the students of the dental schools; and if the other dental schools have dental societies, what earthly reason is there why we should not? My medical friends will, doubtless, at once say, "You have the Physical Society; why should you want a Dental Society as well?" I have not a single word to say against the Physical Society, but the subjects that are discussed there are purely medical, and we, as dental men, have naturally not so much interest in medical as in dental research. We feel that one evening a session is not enough to give to the discussion of dental subjects. I know it is not possible for the Physical Society to give more time to dental research, and I do not blame them for giving no more than one evening, because I know that there is quite enough in the medical world of thought to excite their attention without giving any time to dental subjects whatever. I wonder that they give even one evening. I feel confident that my medical friends, after looking at the subject before us now with unprejudiced eyes, will fall in with my views, and will not think that we (dental men) are trying in any way to separate ourselves from them, but will see that we are doing, as I trust they are, all that we can in our power to push forward the fame and the notability of our great and noble Hospital.—Yours very truly, W. J. OLIVER DAWSON.

Medical Work in Beluchistan.

Dear Sir.—Since my arrival in this country I have been moved about a great deal, and the Gazette, until some time back, has been forwarded from Manchester. Will you now send it c/o The Principal Medical Officer, Quetta. I was at Netley with one of your old house-physicians, Austin Smith, and we came out in the same trooper. There is a detachment of a native infantry regiment and some native cavalry here, sent to back up the newly installed Khan. This is a bare hilly country, about a week's march from Quetta, and bitterly cold, bar

the sun, at about seven thousand six hundred feet. The wild Beluch lives in tumble-down mud villages surrounded by mud walls. The people, from the Khan downwards, are filthily dirty in their habits. There is little to be done here in the way of surgery. At Jacobabad, in Sind, where I was for three months, there is plenty of stone and some cataract and hepatic abscess. The native does not, as a rule, come for treatment until his trouble quite prevents his working, and even then not until he has given prayer an extended trial. When they do come to hospital it is necessary to operate straight off; if you wait till to-morrow they have changed their mind and left. One can rarely, therefore, prepare a case for operation. Every patient comes to hospital with three or four relatives—a three-year-old boy with stone is accompanied by his father, mother with the baby, father's mother-in-law (she is always there), and perhaps one or two more. They live in the hospital compound. As all these people are, for the time being, voluntarily out of work, they are anxious to return to their homes as soon as possible, and the patient is often taken away from hospital before healing is complete. In the case of recurrence they decline further operation—"Kismet!" Murders are frequent in Upper Sind, and almost all are the outcome of quarrels about water supply. The whole of the cultivation is dependent on irrigation canals which bring water from the Indus, sixty or a hundred miles off. One native cuts off his neighbour's water supply and takes it unto himself; his dead body is then brought in by the native police, and after a journey of about three days in a temperature over one hundred degrees, the civil surgeon has the pleasure of examining it. The Sindhi spade is the usual weapon of offence, it is shaped like a large adze. The temperature in Jacobabad from June to September rarely falls below one hundred at night and is one hundred or one hundred and sixteen in the shade by day. You sleep on the roof under a punkha.—With all good wishes for 1894, believe me, yours sincerely,

Kalat, Beluchistan, S. H. BURNETT.
6th January, 1894.

The Smoking Concert.

ON February 24th the monthly smoking concert took place. An improvised programme was capitally given (and somewhat too rapturously encored). Mr. Muncaster was in the chair.

The best bits of the evening were probably the violin solos of Mr. S. Wright and the songs of Mr. Harding. Among novelties, Mr. Bligh scored heavily with "Bludso's Ghost." Mr. Allport, Mr. Coulson and Mr. Lulham, as old favourites, sang and played in their usual form. Mr. Layman gave the "Irish Parliament," with a topical verse which was rough on the Debating Society. Among Mr. Lulham's new phrases perhaps the best was "A Laird of Contango," as descriptive of a London financier turned into a Scotch landowner.

Guy's Hospital Annual Boxing Competition.

THE annual boxing competition, which came off in the Pavy Gymnasium on Wednesday last, was not a very large affair, but it was excellently managed, and gave an evening's enjoyment to all concerned. To see Martin officiate with the sponge and bottle was itself worth the money, and the bout between Morgan and Henry was right excellent sport. One or two of the events were perhaps a little one-sided, but an excellent sportsmanlike spirit prevailed throughout. We noticed amongst the spectators Messrs. Higgins, Dunn and Rowell, and Drs. Bryant and Fawcett. Morgan, who won both the competitions (10 stone and "Any weight" respectively), and also the prize for style, was heartily congratulated by all concerned.

The officials were:—Referees, Messrs. Angle and Cousins; M.C., Mr. H. J. Spon; seconds, D. A. W. Martin and Bill Natty.

Mr. Spon deserves great credit for the manner in which the arrangements were carried out.

10ST. COMPETITION.—E. Morgan beat H. Izard; A. W. Powell beat D. Cogan; final, Morgan beat Powell.

ANY WEIGHT.—P. F. Henry beat C. E. Michael E. Morgan beat A. T. Pearce; final, Morgan beat Henry.

Pavy Gymnasium.

THE Fourth Annual Gymnastic and Fencing Competition will be held on Thursday next, March 15th, when it is hoped that the affair will be made a "Ladies' night."

The Club is again greatly indebted to Dr. Pavy for presenting squad prizes in the gymnastic competition; to "An old Guy's Man" for presenting special prizes to the best gymnast and best fencer and boxer respectively; and to Mr. Skinner for presenting prizes for the boxing competition. Mr. Golding-Bird has also promised a prize for the fencing competition.

Dr. Pavy will, as usual, preside, and has kindly consented to distribute the prizes to the successful competitors, and a large number of members and friends will, it is hoped, be present to welcome him.

Charles Kingsley on Medical Students.

"YOUR early life may be a coarse—too often a profligate—one, but you know the people, and the people know you; and your tenderness and care, bestowed without hope of repayment, cheers daily many a poor soul in hospital wards and fever cellars, to meet its reward some day at the people's hands. You belong to us at heart, as the Paris barricades can tell. Alas! for the society which stifles in after-life too many of your better feelings, by making you mere flunkeys and parasites, dependent for your livelihood on the caprices and luxuries of the rich."

Sport.

Association Football.

SURREY CUP, SEMI-FINAL.

GUY'S v. WEYBRIDGE.

This match was played on Saturday, February 24th, on neutral ground at Walton. Neither side was fully represented, Weybridge being without Veitch and Wetton, while we were not allowed to play Daniel, owing to his not having played for us three times this season.

A large attendance lined the ropes to watch the game, and it soon became evident that Guy's were their favourites, Weybridge being looked upon as mere pot-hunters in this neighbourhood.

Hewetson lost the toss, and so we had to kick off uphill, with the sun in our eyes.

Our forwards took up the running at once, and several smart runs were made by Walter and Davies, from one of which Stamford beat Spyers with a grand shot, thus opening the score for Guy's after about ten minutes' play. Weybridge had now got their blood up, and Pares and Cotterill inaugurated a good run, which was becoming dangerous when Carter pulled them up in fine form. Weybridge now began to press desperately, and it was undoubtedly due to Cooper and Carter's steady play that they did not score on two or three occasions. Ultimately however, by a mistake on the part of one of our backs, Paine scored an easy goal, and thus made the score one all. This put our forwards on their mettle and from a good shot of Crosby's, which struck the crossbar and came back into play, Davies, with a hard low kick, gave us the lead just as the whistle blew for half-time, Guy's thus leading by two goals to one.

On resuming, we had to play downhill, and, as is customary, our forwards had a quarter of an hour's "slack," during which time Weybridge were often dangerous and giving our backs plenty to do. Still, by good play, they were kept out until the referee gave a foul off Cooper—a wrong decision we thought, as the ball never went near his hands; however, they got a free kick about ten yards from our goal, and managed to equalise (two all). Then our forwards at last woke up and made a really good rush into the Weybridge quarters, a good shot from the left was caught by their goal-keeper, who ran more than the allotted two steps, in consequence of which we were awarded a free kick close to their goal. Stamford took it, and passed to Fitzhugh who, although Weybridge packed their goal, managed to get it somehow between their legs into the net, thus giving us the lead once more. There now remained only seven minutes to play, and Weybridge made their last effort, but Carter and Lidderdale were as safe as a rock, and when the whistle blew we left the field winners by three goals to two, amid great enthusiasm and hearty congratulations from the spectators.

The following criticism is taken from the *Surrey Advertiser*:—

"The game started at a tremendously fast pace, and within ten minutes of the kick-off Guy's made the Weybridge partisans somewhat disheartened by opening their account, but the Weybridge players, by some determined play, equalized fifteen minutes later. Again the play was very even, but just before half-time Guy's made a spurt, and registered a second goal to their credit. On changing over, each side in turn became dangerous; but Weybridge were not to be denied, as they once more made matters level. As eleven minutes now only remained to play, a draw seemed imminent, but Weybridge's success immediately drew from Guy's Hospital a third point, and the Medicals thus gained a sensational victory by three to two. The result fairly represented the merits of the teams on the day. N. C. Cooper, the old Cantab, marked Cotterill with effect, whilst A. B. Carter at back was more than equal to the remainder of the Weybridge attack. Rarely has the last-named player been seen in such grand form, and it must be admitted that he and Cooper won the battle for the Hospital. The winners also shewed a sterling attack and exhibited better combination than the losers.

"Outside Weybridge, the victory of Guy's Hospital has been warmly received, as not only are the Medicals a popular team, but the change of hands of the Cup is calculated to benefit sport in the county." Teams:—

GUY'S.—N. Lavers (goal); A. B. Carter, F. J. Lidderdale (backs); H. Hewetson (captain), N. C. Cooper, A. E. Crosby (half-backs); F. E. Walker, E. C. Davies, R. T. Fitz-Hugh, R. B. Stamford, L. Humphry (forwards).

WEYBRIDGE.—R. T. Spyers (goal); E. B. Eyre, H. Anstead (backs); B. Pares, E. Hicks, R. H. Walker (half-backs); A. Wedd, N. Paine, G. H. Cotterill, E. M. Tringham, J. R. Westwood (forwards).

HOSPITAL CHALLENGE CUP.—SECOND ROUND.

GUY'S v. ST. BARTHOLOMEW'S.

This match was played on Thursday, March 1st, on our new ground at Honor Oak, before several hundred supporters of the two Hospitals. A more miserable day for football could not well be imagined, it raining hard most of the time that the game was in progress, with a strong wind blowing straight across the field. The ground had been marked out over the cricket pitch, and was in much better playing condition than might have been expected considering the recent rains. Guy's having lost the toss, Bart's. elected to play with the wind for the first half. Fitz-Hugh kicked off for Guy's against the wind, amid cries of "Play up Guy's," and "Go it Bart's." It was soon evident that Bart's. meant to make the most of the wind, for their forwards were soon swarming around our goal, and Fernie had two very good chances of scoring, but he did not take

advantage of them, but dwelt too long on the ball and then shot wide. Our backs were having their hands about full just now, but they all played up well, Carter especially shewing to advantage, and Daniel stopped Woodbridge several times very neatly. At last relief came by the right wing, Walker getting away and passing to Hibbard, who passed to Fitz-Hugh, who sent the ball right out on the left wing to Stamford, who, getting possession, made a good effort to score, the ball passing across the mouth of goal and going behind. From the kick-off Bart's. again passed, until Cooper relieved and passed to Fitz-Hugh, who again passed out to Stamford, with the same unfortunate result, that the ball passed in front of goal and went behind. Bart's. continued to press, Woodbridge and Fox being most conspicuous, and Mackintosh being a great stumbling block in the way of our forwards.

However, half-time came and nothing had been scored —to our great relief—so we crossed, feeling that now, with the wind, we had a good chance of winning.

The game had only been in progress about ten minutes, when Stamford, after a good run on the wing, centered neatly, and Fitz-Hugh put in a hot shot, which Fryer saved and threw out, Cooper, however, getting possession, shot again, and Fryer not being able to get anywhere near it, Guy's scored a goal, and as it turned out, the only point obtained during the match. Guy's continued to press, and ought to have scored on one or two occasions, but with a slippery ball it was by no means so easy as it looked. In the last quarter of an hour Bart's. made some desperate efforts to pull the match out of the fire, but our backs were always there, Crosby on one occasion making an incredible save. At last the whistle sounded time, and we were returned winners by one goal to nil.

On coming to the individual players, it is impossible to criticise, where all played such a sound game, especially the back division, amongst whom Carter and Cooper might be mentioned as being especially brilliant, and of the forwards, they played as well as could be expected of them on such a bad day, accurate passing being impossible with such a wind blowing, and with a wet ball, but Walker and Fitz-Hugh might be mentioned as working especially hard. Team:—

Guy's.—N. Lavers (goal); A. B. Carter and F. J. Lidderdale (backs); A. M. Daniel, N. C. Cooper and A. E. Crosby (halves); R. B. Stamford and H. Hewetson (left wing); R. T. Fitz-Hugh (centre); C. E. Hibbard and F. E. Walker (right wing).

GUY'S 2nd XI. v. CITY OF LONDON SCHOOL.

This match was played at Denmark Hill, on Saturday, March 3rd, in grand weather. We lost the toss, and, consequently, had to play uphill and facing the sun. The defence of the School was very good, and, although we pressed severely, yet we were unable to score, our shots being attended with bad luck, one from Brookhouse striking the cross-bar. Half-time arrived with no score to either side. In the second half we shewed better combination, and Humphrey shot two goals in quick succession, followed by one from Miller, neatly put through from a corner, and we thus won by three goals to nil. Mules in goal was very safe, while our backs and halves showed an excellent defence, and in the second half our forwards improved and played well together Davis feeding his wings very well.

Team.—J. Mules (goal); C. King, E. A. Longhurst (backs); R. Marsh, E. J. Crewe, R. Hayes (half-backs); A. Miller, E. C. Davies (right wing), E. J. Davis (centre), L. Humphrey, C. S. Brookhouse (left wing) (forwards).

Rugby Football.

INTER-HOSPITAL RUGBY CUP—THIRD ROUND.

GUY'S v. ST. THOMAS'S.

This important Cup Tie was down for decision on Tuesday, February 21st, but owing to the hard frost prevailing at the time, it was postponed till the following week. It duly came off on Tuesday, February 28th, on the Richmond Athletic enclosure, before probably about 2,500 spectators. Of course, there was the usual crush at Waterloo previous to going down, and perhaps the most interesting man amongst those who carried musical instruments was he with the railway bell; though repeatedly ringing it, he did not call forth the censure of the officials. Among our staff we noticed the familiar faces of Drs. Goodhart, Savage, Pitt, Shaw and Fawcett, and Messrs. Durham, Davies-Colley, Lucas, Brailey, Dunn and Fripp, together with numerous old Guy's men—all sanguine that their representatives would win. Such, however, was not to be the case, for after one of the poorest and most uninteresting of games, we were defeated by the narrow margin of one dropped goal to nil.

Before commencing with the account of the game itself, we feel inclined to just vent a little hitch that occurred this year previous to the match being played. Everyone is now familiar with the "Jackson question" from its birth, and that our committee did quite right in leaving him out when they first selected the team will be admitted by most people, though there are differences of opinion on that point. But an unforeseen circumstance cropped up. Jones got laid up four or five days before the match; and the question arose—would he be fit to play? This was answered by those outside the committee, most of whom are good judges of what is required of a cup tie player; and the general opinion was "No." They argued, and quite rightly, "let us be on the safe side, and if Jackson is willing to play, let him play." But Jones played, and it was evident to everyone that he neither did himself justice, nor his side. Well, this incident strikes one as having a good deal to do with our downfall. Guy's certainly had great ill luck in losing the services of such a player as Hancock, but it is fairly certain that had he played the result would hardly have been different, provided the game was played on the same lines as adopted the other day.

The Game.—Stoker kicked off against the wind at a quarter past three, and play almost immediately settled down in the Thomas's quarters, but the ball was gradually worked back to the centre, and scrums were evidently the order of the day. Rowlands then came away in fine style to their twenty-five, but aided by the wind, Thorman kicked to the centre, scrum after scrum was formed, a long time elapsed ere the ball got loose. Jones distinguished himself later on by saving extremely well. Thomas's men gradually forced us back and Alexander saved by touching down. After the ball was set going, Thorman received and evidently was bent on dropping a goal, but Bell frustrated his efforts entirely. Guy's, however, were soon penned in on their line again, and Jones saved several ugly rushes. Ultimately, relief came by Slater and Rowlands dribbling away. We touched down twice after this, soon after one another, and Thomas's managed to keep us fairly in our twenty-five. chiefly by dint of hard kicking aided by the wind. Nothing noteworthy occurred much before half-time, when, from a line out, Thorman received the ball and dropped a neat and clever goal. Half-time then sounded. Well, this seemed a trifle unlucky for us, but the general opinion seemed to be that Guy's would certainly score when they had the wind, provided their backs had the opportunities. After a lengthy interval, the ball was set going, and Guy's pressed; Thomas's relieved with some passing between their backs, almost the only passing seen up to now. Stewart saved several times. By a combined rush of our forwards, the ball was carried perilously near Thomas's line, and if we had passed out, we seemed bound to score. However, somebody did actually get over the line, but he was certainly held outside, and the ball brought back five yards. Thomas's got away, but Alexander replied with a fine kick into touch. For once in a way Bell received the ball, but little was done. Guy's forwards were playing up splendidly, and never having the worst of a single scrummage they at times bested their opponents. Eventually, play settled down at the half-way flag. Thomas's dribbled back, but Alexander saved splendidly, and returned the ball to mid-field. Stoker came away, and a little later on was called upon to save; though held, he kicked into touch. Play became entirely uninteresting up to the finish, and calls for no comment. Nothing more was scored, and Thomas's again defeated us by the narrow margin stated above. Teams:—

Guy's.—K. B. Alexander (back); H. M. Stewart, H. T. Bell and T. Wetherell (three-quarters); R. Mathias and M. R. Jones (halves); F. O. Stoker, E. T. Shorland, L. Slater, R. S. Rowlands, C. D. Edwards, C. R. Nicholson, W. Tyson, E. D. Hancock and H. W. Dudgeon (forwards).

St. Thomas's.—C. B. Moggridge (back); E. W. Browne, W. H. Thorman and J. Ogilvie (three-quarters); A. Montague and A. Rotherham (halves); W. Ashford, A. E. Elliott, J. Carver, H. R. Sedgwick, A. Rouillard, F. C. Adair-Thompson, G. H. Dominey, H. Haward and F. Bingham (forwards).

Referee: Mr. E. T. Gurdon (Richmond).

Remarks.—As will be surmised by those who did not view the game, it was a forward one throughout, Thomas's as usual making the very best of their forwards, where their great strength undoubtedly lies, and Guy's half-backs aiding them in keeping the ball tight, inasmuch as soon as the ball had been nicely heeled out, they only ran round the scrummage till collared, in a useless manner, instead of giving their backs every opportunity of scoring. Our forwards played a sound, honest game, and it is difficult to individualise. The names of Rowlands, Slater, Stoker and Shorland perhaps deserve special mention. The halves have been dealt with, but in fairness to them it must be admitted they tackled and saved admirably, but it should be thoroughly understood that Jones was playing under considerable disadvantage. The three-quarters had nothing whatever to do with running with the ball, but they, however, showed fine defence, Wetherell having least to do. Alexander, at full back, was as cool as the "proverbial cucumber," and did everything he was called upon to do in perfect style.

Amongst Thomas's men, their forwards all worked hard, and Montague at half, shewed good defence. Thorman's goal was as clever as it was sharply done. With these remarks I trust no one will think I have judged too harshly, for the team have our congratulations for the excellent form exhibited this year, and winning many good matches, but as regards the Cup tie, amongst others, they have sadly disappointed yours truly,

S. E. L.

Marriages.

CARRELL—HADDOW.—On February 24th, at Barry Road Wesleyan Church, George N. P. Carrell, M.R.C.S., L.R.C.P., of Ilford, to Sage Ward, daughter of Nathaniel Haddon, of East Dulwich.

EASTMENT—WALKER.—March 1st, at St. Mary Magdalene's, Addiscombe, by the Rev. John Walker, assisted by the Rev. Henry Glover, Vicar, John Willot Eastment, M.R.C.S., L.R.C.P., second son of the late Francis Meade Eastment, Drayton, Somerset, and of Mrs. Eastment, of Surbiton, to Frances Mary, only child of Mr. and Mrs. T. W. Walker, of Addiscombe, Surrey.

PARRY—LAMBERT.—On March 3rd, at St. Paul's, Thornton Heath, Surrey, by the Rev. G. Lewis, M.A., Ernest J. Parry, B.Sc. Lond., Assistant Chemist to the London County Council, to Jessie Frances, eldest daughter of Mr. Samuel H. Lambert, of Edinburgh House, Thornton Heath.

Deaths.

WASHBOURN.—On February 26th, at 15, Trinity Square, S.E., Nellie Florence, the wife of J. Wychenford Washbourn, M.D., aged 22.

WHEELER.—On February 26th, at 11, Museum Terrace, Chelmsford, Daniel Wheeler, M.R.C.S. Eng., L.S.A., aged 75.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual subscription to the Gazette *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers, who may be desirous of having their numbers of the Gazette *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette,

MARCH 31, 1894.

Mr. Durham's Last Clinical.

By generously postponing the delivery of his last Clinical Lecture, in order that Guy's men might, with easy consciences, see their Association Football Team win the Inter-Hospital Cup, Mr. Durham relegated himself to the chances of a vacation audience. From one point of view this was just as well, for anatomical theatres are not proportioned for demonstrations of popular regard during the height of the session, and—vacation notwithstanding—the Theatre last Wednesday was packed to hear our late Senior Surgeon's last words as a teacher in his old School. Mr. Durham's appearance was the signal for a very thunder of applause, and as this died away the familiar voice was heard thanking them for such a reception. He was not going that day to give an ordinary clinical lecture, but rather to make some general remarks upon the importance of clinical study. Guy's had always been distinguished as an excellent school for clinical study, and the facilities afforded to students for pursuing their clinical observations were such as did not prevail at any other London institution. It was a tradition of the place which had come down from 1772, when a public advertisement appeared giving notice that such facilities would henceforward be found at Guy's Hospital. Then, under Dr. Addison, one of the greatest clinical teachers who ever lived, a system of case-taking was established. He remembered Dr. Addison and his lectures better than anything during his career. Lectures so admirable and impressive were recollected with the most remarkable ease. Things, however, were very different in those days to the present. The whole course of study was different. There were then no five examinations to be passed before qualifying. There were no special subjects to be studied, requiring time, skill and patience, apart from the work in the wards. The microscope was only used casually. Instead of section cutting and staining which goes on now, there were only dissections in the dissecting room. He was afraid, however, speaking from recollection, that although having less to do, men did not in that day spend more time on their clinical study than they do now. Still it was true that at Guy's Hospital clinical study had always been encouraged and helped, and the result was that Guy's men generally were distinguished by their practical knowledge. A very eminent surgeon, belonging to another hospital, whom he had met some time ago said, "You know I like to meet your Guy's men, they always seem so well up in their cases"—and he had replied that that was the result of the encouragement they had given them to study at the bedside. And yet one often found there were not so many men availing themselves of the opportunities afforded them in this respect as there might be. An American medical friend, after a visit to Guy's, said to him, Mr. Durham, "It is all very well, I like your way of going on very much: I like the quiet and orderly method, but I don't understand how it is you don't have more of the men going round with the surgeons and physicians, because there are plenty of them about somewhere." And so, in order to make things comfortable all round, he had to explain to the American doctor that, at the time he was going round, the various students were busy preparing for their examinations. Here Mr. Durham's audience laughed immoderately, but whether in accord or in disagreement with his explanation we hesitate to express an opinion.

As an illustration of the importance of clinical study, the facilities afforded for the same at Guy's, and the duty of students to avail themselves thereof, Mr. Durham proceeded to take a full list of the cases which happened to be under his care at the moment, and made a rapid survey of their nature. He did not advise students to confine themselves to their own Surgeon or Physician, but, after having attended to their own special duties, to look at what everybody else was doing. That most excellent publication, The Guy's Hospital Gazette, had attempted, and to a certain extent succeeded, in giving from time to time, particulars of the more important, interesting, and rare cases in the wards. He wished to encourage the Gazette, and was quite sure that a simple list of interesting cases put in at the last minute would be very useful; and he was further sure that the Editors would be very glad to have intimation of such cases from the proper quarters. Mr. Durham then proceeded to epitomise and comment upon the clinical material at present to be found in Cornelius and Martha wards. This commentary, which we regret to be unable now to give at length, was interspersed with many good things. For instance, students were told that they could not be too experienced in dealing with fractures. It was not pleasant for a practitioner to see a man whom he had treated for fracture go hobbling about for life. Patients in a hospital went away and might never be heard of or seen again, but in a rural

practice the patient remained either as a credit to the practitioner or the reverse. He should never forget a medical friend of his in the country, who had somehow never successfully learnt to deal with fractures. He had called him down to see a case, and, as they walked along the street to the patient's house, he suddenly seized his arm and said, "Come down here," at the same time pulling him down a byeway. He asked him what was the matter, and his friend replied, "There is a man who broke his leg, and somehow I did not manage to make a good job of it; now he always comes up to me and says: 'Oh, doctor, my poor leg is no better.'" That sort of thing was particularly humiliating.

In dealing with a case which had been in the Hospital since July, 1893, Mr. Durham incidently remarked that one of the distinguishing features of Guy's Hospital had been that patients should be allowed to remain in so long as there was any likelihood of their deriving benefit from the Hospital. Old Thomas Guy, when a governor of St. Thomas's Hospital, was not quite satisfied with that institution, because he so frequently noticed that poor patients were sent out of the wards before they had acquired all the benefit they ought to have done, and he determined to build a hospital himself where this defect should be remedied. A case of chronic abscess of the breast drew from the lecturer some sweeping observations. "Cancer of the breast and axillary glands. It seems to me year by year there are more of these cases, and I would say, do be on the look out for them and put the matter plainly to the patient that the thing is of such a character that it must be got rid of. Only last night I had a letter asking me to see a lady to-morrow with feared cancer of the breast. Another letter of the same kind came this morning. Now, if these cases had been recognised and treated a year or eighteen months ago, early recognised, early treated, these ladies would have been well now and free from anxiety. It used to be said that something like two years was the limit of life after cancer had developed itself, but we know now that after recognition and complete removal the time is very much longer. There are cases about now on which I operated twelve and fourteen years ago. In the case of the old fellow to whom I referred the other day in my lecture, it is twenty years since, and I saw quite recently an old lady whose breast I removed longer ago than that. There is nothing to be done but to recognise these cases early. It is no use waiting to see. Cancer is a most pitiless enemy, therefore have no pity on it, extirpate it root and branch."

In conclusion, Mr. Durham asked his hearers for time to impress upon them a few points. First, not to be attracted only by the peculiar and rare cases, but to give their attention to the comparatively common types, because it was with regard to those, when they got into practice, that they should be well posted up as to the methods of recognition and treatment. Secondly, he recommended students to familiarise themselves with the mechanical aids to the senses now obtainable, and to practice themselves in the use of every instrument which would assist them in diagnosis and treatment. Lastly, he would venture to say something which they might think hardly necessary. It was with regard to their treatment of the patients. "You have to acquire knowledge for yourselves, but you have to do that at the least possible suffering to the patients. You cannot be too kind, too considerate, too gentle to patients in your dealings with them, and it will be to your profit that you should be so always. You will be adapting yourselves to and cultivating the manners which your future patients will expect of you. You may have no idea of the difference it makes. If you are impatient you will find you cannot get anything out of the patients at all, but if you are kind and considerate you will be surprised to find how much you can learn from them. And, gentlemen, if you are to be successful in your future lives—and I trust most devoutly you may be—you must be patient in carrying out your treatment. Do not expect that you are going to get your patients well at once. Don't get sick and disgusted of your cases. Do not show that you are, at any rate. I know how trying patients are at times, but I say, without hesitation, that I have never been angry with a patient—without being sorry and repenting for it afterwards. Recollect this, take it as your motto, as did Colin Campbell, Lord Clyde: "By patience, common sense, and time, seeming impossibilities become possible." My last words will be, to express my heartfelt wishes for you all, your happiness and success in life, your prosperity in the positions you will be called upon to occupy; and may you continue to be proud of being Guy's men, as proud as others may be that you have been such. I cannot thank you adequately for all the kindness I have experienced at Guy's. If I have ever been angry with a patient, I have never done anything else than regret it. I cannot say I have ever been angry with a Guy's student, because I do not think I have. I may have been angry at things which were done, but not with the man himself. I have never had anything but the kindliest feelings towards Guy's students, and I believe they have always had the kindliest feelings towards me, and in saying farewell, I shall hereafter bear in mind all the friendships I have made here, all the kindness bestowed upon me by friends and students in Guy's Hospital. Now I will say no more except, God bless you all."

From first to last the occasion was most impressive, because of the very simplicity and dignity which characterised the proceedings. There was absolutely no premeditated display. With the exception of an occasional burst of laughter at Mr. Durham's sallies hardly a sound escaped from the mouth of any student, and demonstrations of applause were confined to hand clapping. As the lecturer neared the close, his audience became subdued to a stillness that was almost oppressive, and at last, by some simultaneous impulse, rose like one man as if to receive the parting benediction. Then, amid a storm of hand-clapping, still unmixed with the shouts of mere boisterousness, Mr. Durham, with lingering step, passed from view.

Notes of Dr. Shaw's Demonstrations in Pathology.

ADRENALS.

Presenting a central cavity, often found as a spherical cyst.

Hæmorrhage (2022[5]) into the medulla, owing to looseness of the tissue; gives rise to no symptoms.

Lardaceous (2021[15]), enlarged, translucent and firm.

Adenomata (2022[4, 5 & 7]) appear as white nodules, to the naked eye indistinguishable from tubercles, but microscopically of the same structure as the white part of the adrenal; of no pathological importance.

Malignant disease, never gives rise to Addison's disease and is generally secondary.

Sarcoma (2021[36], 2022[14]).

Carcinoma (2021[50]).

Tubercle.

(*a*) Miliary, of no clinical importance.

(*b*) Addison's disease is not commonly found associated with tubercle in other organs of the body, except in caries of the spine, hence some pathologists are inclined to doubt its tubercular origin. The possibility of the disease being due to lesions of the semilunar ganglia is raised, but this lacks post-mortem confirmation. The conditions of the bodies may be classified as,

(1) Caseous deposit (2020[32, 65 & 68]), causes enlargement.

(2) Fibroid growth (2021[80 & 82]), causes shrinking.

These are obviously successive stages of the same process. The suprarenal tissue in this disease is entirely destroyed, though it is not so destroyed by other affections.

KIDNEY.

A. Congenital peculiarities.

(1) Lobulation (2024[10], 2022[75]), a persistent fœtal condition.

(2) Single (2022[25], 2026[20]), not very rare, usually hypertrophied.

(3) Horse-shoe (2023, 2023[50]), the point of union being below.

(4) Misplaced (floating) (2022[60], 2022[58], 2022[61]), liable to be mistaken for a malignant growth; and when on the right side, as is commonly the case in women, for a distended gall-bladder.

(5) Mis-shapen (2022[75]).

(6) Vessels abnormally placed (*see* Hydronephrosis).

(7) Cystic.

B. Hypertrophy (2026), an overgrowth of the normal kidney tissue. Causes, (1) disease or incompetence of the other kidney, (2) overwork in drunkards and diabetics.

C. Atrophy appears always in cases of fibroid induration, but little is known of a true atrophy.

D. Inflammation.

(1) *Suppurative.*—This may produce—

(*a*) Abscess (2032, 2072[20]).

(*b*) Scar (2035[40]), a depression on the surface, originating from an ascending nephritis which has not gone on to suppuration. There is some interstital change in the tract between the scar and the pelvis of the kidney.

(*c*) Perinephritic abscess (2032), which may give rise to all the symptoms of lumbar abscess, and it may open into the colon or externally.

Suppuration may follow some constitutional diseases.

(1) Surgical pyæmia (2033[10 & 20]); these are generally supposed to be embolic.

(2) Ulcerative endocarditis–infarction (2022[80]). If no micro-organisms are present in the embolus a scar is formed without an abscess.

(3) Tubercle; *miliary* (2035[92 & 93]), may be mistaken for fibroma, but the tubercles are more numerous and are associated with tuberculous lesions elsewhere. It is difficult to see the tubercles if the kidneys are anæmic. *Caseous* (2028, 2069[30]), have the abscess wall, are very conspicuous, but there is not much abscess cavity. There are often putty-like masses round the pelvis, and the pelvis and uterus are generally involved. *Calcareous*, a later stage of the former.

The mode of infection is by way of the renal artery in miliary tubercle, whereas in the caseous form infection is conveyed upwards along the urinary tract.

From the Gazette's Special Pathologist.

W. T. H., BASCHURCH, SHROPSHIRE.—Epithelioma of lip.

H. D., HIGHGATE.—The sputum sent contains blood and large oval malignant cells, many of which are deeply pigmented.

A. H. W., ST. LEONARDS.—Tubercle bacilli were found in the urine sent.

W. O., COVENTRY.—Tubercle bacilli present.

C. W. W., HITCHIN.—Tubercle bacilli present.

H., CATERHAM VALLEY.—Tubercle bacilli present.

F. R. B. B., TUNBRIDGE WELLS.—The urine contains, besides albumin, a large number of albuminous casts. No sugar or blood found.

PATHOLOGIST.

Specimens for examination and description in this column, should be addressed to H. HUNT, GAZETTE, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

A Case of Puerperal Eclampsia.

The successful termination of this case, brought about, I believe, by saline transfusion, must be my excuse for bringing it under your notice.

On December 23rd, I was called to see a primipara aged 25, who was said to be suffering from swollen legs. She told me that she was eight months pregnant, and that for the last month she had passed very little urine. Her legs, which had been swollen throughout her pregnancy, had increased a good deal in size during the last month. Her family history was unimportant, except in the fact that a sister suffers from epilepsy. I found her in bed with the legs a huge size, and face and arms both œdematous. Her urine, which was very scanty, contained two-thirds albumin. I regret to say that no estimation was made of the urea excreted; the busy time I had in the treatment of the case must be my excuse for any laxity in scientific observation.

I saw the case at 5 p.m., and at 10 p.m. there was a note she was in convulsions. There was no sign of labour, and she had had some four or five convulsions during the hour I was being fetched.

Following a maxim which only a few nights before Dr. Barnes had impressed upon me, before making any examination I put her under chloroform fully.

The os was just big enough to admit my finger, the head presenting high up. With a hair-pin I punctured the membranes; kept her under chloroform; gave some chloral and bromide, and then slowly let her come to. Result, more convulsions; more chloroform.

As any cessation of the administration only resulted in the same terrible result, I decided upon emptying the uterus—the child was the cause of the trouble. At all costs the child must be removed; then came the tug of war. The os was just large enough to admit my finger, and the vagina was small. However, after many failures, I at last got the os sufficiently dilated with my fingers to take a small Barnes' bag, until at last it took the largest I had with me; but whenever the Barnes bag was removed the os shut up like an india rubber-ring. With great care I applied the forceps; traction brought down the whole uterus; the os would not give an inch. However, I had made up my mind that removal of the child was the only course, and as the head could not be brought whole through such a passage, the next thing was to perforate; this was easily done, and it seemed at first that all would go well; but no, traction only dragged down the uterus. Then, after two hours' hard work, I left off to see what Nature would do; no pains came, and—chloroform stopped—on came the convulsions. I hope the *accouchement forcé* is not terribly bad midwifery, but what else was to be done; after a big struggle with a tightly contracted uterus, I turned and delivered.

Then, at last, at 4 a.m., one hoped the worst was over; very gradually I let her come back from the chloroform, but once again commenced the most frightful convulsions I have ever seen. I believe in a case in which convulsions go on after the uterus is emptied the prognosis is very bad, and I began to despair of my patient.

Next came pilocarpine, which produced most free sweating, but it also produced equally free bronchial secretion; when she was conscious she coughed this up, but after a fit she was simply drowned in it, and once or twice I thought she was dead. I do not think that the injection of pilocarpine is an experiment I shall ever repeat; nothing ever gave me greater relief than when I saw its effects gradually wearing off. One is perfectly helpless with an unconscious patient and such a flood of bronchial secretion.

Fit after fit came on and then a condition of constant restlessness and twitching. Then I decided upon transfusion, with the idea that a copious injection of saline fluid would dilute any poison acting upon the "convulsive centre." It was almost impossible to find a vein, the arms were so œdematous; but after a careful search the median basilic was at last exposed. No blood came from it, and for the simple reason that I had forgotten to remove a ligature from the arm, put round it to make the vein show up. No fluid would run into it from the canula; in disgust I removed it, stitched up my wound, and saw with greater disgust the cause of my failure. In my case I had a large sharp-pointed canula, made for me by Messrs. Downs, to meet emergency cases, where one might have no time to dissect out veins; as they told me that Mr. Morse, of Norwich, had successfully transfused into the subcutaneous tissue, I plunged this sharp canula into the fat of the loin, or rather beneath the fat, and was delighted to find that my saline solution ran into the tissues as quickly as Dr. Horrocks' funnel would carry it. After a pint had been poured in my patient was quiet; colour came back to her lips, and the twitching ceased; another pint, and she was apparently in a sound sleep. This was at 6 a.m.; at 8 a.m. I left her asleep; at 9 a.m. she had two more fits; at 9.30 a.m. she had convulsions and twitchings every two or three minutes. Once more a quart of saline fluid, and the same sleep was induced; this time I backed it up with a hypodermic injection of morphine gr. one-sixth, and I am pleased to say she never had another fit; in forty-eight hours she was conscious; and in three weeks was downstairs as though nothing had happened, with every trace of albumin gone from her urine, and no œdema.

On examination, there was a very slight laceration of the os as the result of my prolonged interference. For twenty-four hours she passed scarcely any urine; then secretion started and the kidneys worked with a will, getting rid of over a gallon in the next twenty-four hours, and it is of this urine which I regret no proper examination was made.

What is of special interest in these transfusion days was the rapidity with which the fluid injected into the subcutaneous tissue was absorbed. Two hours after there was no trace of the quart of water; it was appreciably less in half-an-hour. But nothing seems to strike those to whom I have related the case so much as the thought of what terribly bad treatment a woman will stand. The chloroform was most ably given all night by a midwife, through a Junker.

Liss. H. E. COUNSELL.

Physical Exercise.

A Paper read before the Physical Society, January 20th, 1894, by Mr. F. J. Steward.

Mr. President and Gentlemen.—Before proceeding to the subject of this evening's paper, may I be allowed to express my appreciation of the honour which has been conferred upon me, in being allowed to appear before you in my present capacity. The subject which I have chosen, namely Physical Exercise, is one, the consideration of which, I thought, must have some interest for everyone present. But, gentlemen, I shall not be able to consider it in any way fitting to either its interest or importance, but shall have to content myself with mentioning a few points about two of the many sides of the subject, and I hope that after I have finished, you will rather enlighten me on some of its other sides, than criticise my feeble, and I fear barren, attempt. I propose, then, to say something of the immediate and remote effects of physical exercise on the various parts of the human body, in the first place considering the general physiological effects, and in the second place, the various pathological conditions which have been attributed to muscular work, in one form or another.

First let us consider the *muscles*. The effects of contraction on a muscle are already well known to you, so I will not weary you with them here; there are, however, a few points which I thought would be interesting to mention. The temperature of muscle falls slightly at the outset of contraction, it then rises and remains raised during the whole of the active period and for a short time after contraction has ceased.

Heidenheim has shown that the specific heat of muscle is raised when it contracts, and this explains the initial fall of temperature, since, with an increase of specific heat, an increased quantity of heat is necessary to maintain the muscle at a constant temperature; this extra amount of heat is not immediately available and so the temperature falls.

We know that when a muscle contracts, four-fifths of the kinetic energy used is lost in the form of heat. This subsequent increased heat production will account for the ensuing rise of temperature.

Now this rise of temperature serves a good purpose, for we know that as the temperature rises up to 40° C. muscle will contract more quickly and more powerfully. And this fact is brought out well in ordinary everyday life, for everybody is familiar with the expression "Warming to work," it being the outcome of experience that the muscles answer to the commands of the will more readily, pliantly and powerfully when one is a little warm, as shown by the "preliminary canter" before a race, etc.

Another point is, that since the capillaries of muscle run between the fibres, the vascularity—and so the power of prolonged work—must vary directly as the diameter of the muscular fibre. And Professor Haughton has shown experimentally that the muscles of women are less easily tired than those of men, although inferior to them in force exerted for a short time, and any of you who have nursed a child know how very tiring it is, and yet its mother will carry it about for hours at a stretch without apparent exhaustion.

Turning now to the circulatory system, we know that when a muscle contracts the arterioles which supply it dilate, the result being an increased flow of blood to the muscle, and hence also an increased flow through the veins, the latter effect being added to by the contracting muscles actually compressing the larger veins. The effect of this would be to diminish the arterial tension. But, on the other hand, the heart beats more quickly and forcibly, and the result of this would be to increase arterial tension. So that these two factors tend to counterbalance one another, and variations in the extent of the one or the other determine either an increase or decrease of arterial tension. If, for instance, the muscles are not accustomed to violent exercise, and a sudden call is made on them, they will need a large increase in their blood supply, and if the heart's action is not correspondingly augmented, the result will be a low tension and dicrotic pulse; if, on the other hand, the muscles are in good condition, needing little extra blood when in action, and the heart beats quickly from excitement or some other cause, the result will be a rise of tension. In the former case, the draining away of the blood to the muscles may result in the supply to the brain becoming deficient, and so vertigo and syncope would be caused; in the latter case, the strain falls upon the heart, and—as I shall show later—bad effects may be produced in this way. This last effect, resulting in cardiac dilatation, occurred in the case of a pedestrian, named Taylor, during a six days' walk. After the first day, when he had walked 78 miles, a pulse tracing was taken by Dr. Mahomed, which showed the following points. It required a pressure of four and a half ounces to develope the tracing, the systole was prolonged, the tidal wave sustained, the upstroke short and very oblique. At the same time the man was cold and very distressed. After the third day, when he had covered 122 miles, he had to give up. Dr. Mahomed also made observations on the pulse of Weston, the American pedestrian, during the same race. The observations were all made late at night, after the day's walk. During the first two days, tension gradually fell, as shown by the aortic notch being at a lower point on the downstroke. On the third, fourth and fifth days, Weston took more food, and the tension was higher and the heart beat more forcibly. On the last day, at the end of the walk, when he had covered 450 miles, the tension had fallen very greatly again. Fraser took tracings at Oxford, on the crew of one of the fours during a period of training. The distance rowed was 2½—3 miles, and tracings were taken before leaving the boat-house, and immediately on returning to it. The changes produced were extremely uniform, both on different occasions and on different members of the same crew.

These results were as follows:—The pulse rate on an average was increased from about 68 to about 90; the tracing obtained before starting showed a small beat, and rather high tension; at the end of rowing the upstroke was much higher, the summit was rounded, and the dicrotic notch was more of an interruption of the line of descent than a separate wave. Fraser explains these changes as follows; he says: "The great length of systolic line indicates a general diminution, at the moment of systole, of arterial tension, the result of dilated vessels, the apex being continued for a short horizontal period, showing maintenance of the B. P.,; and the oblique descent and condition of the dicrotic notch, not being a wave, prove that the heart propels a large quantity of blood so as to distend the arteries, notwithstanding their dilatations."

If, however, the exercise is more severe, the heart becomes still quicker, but more feeble, and at last irregular, and at the same time there is some venous engorgement as shown by the distension of the big veins about the root of the neck. I take it that this embarrassment of the heart is brought about by three distinct causes acting together. In the first place, at the end of a deep inspiration, especially when the breath is held, as it often is during severe exertion, the increased pressure in the air-cells impedes the flow of blood through the lungs, and so leads to engorgement of the right heart. In the second place, the actual pressure of the distended lungs impedes the heart, and tends to prevent distension of the right heart, and so causes overdistension of the venæ cavæ and large veins. At the commencement of expiration, when the lungs are less tense, the blood flows from these distended veins, rushes into the right heart, and so leads to its engorgement. In the third place, as Traube has shown, the general arterial pressure is raised in violent exertion before the arterioles are dilated, and this, of course, will tend to embarrass the left heart.

The effect of exercise on *respiration*, at any rate as far as its outward and visible signs are concerned, must be well known to all of us, for who is there here this evening who has not suffered from dyspnœa after running to catch a train? What is the cause of this breathlessness? In answer to this question I think I cannot do better than give a résumé of Dr. Lagrange's explanation. He considers the breathlessness of exertion to be a form of dyspnœa due to excess of CO_2 in the blood, that is an autointoxication of the body by one of its products of dissimilation, namely CO_2. When we remember that the skeletal muscles form nearly fifty per cent. of the body weight, and that CO_2 is one of the most abundant products of muscular action, we can easily judge of the enormous quantities of CO_2 which must be poured into the blood during any violent exertion, such, for instance, as running. The absence of breathlessness in some forms of exercise is explained by Dr. Lagrange in the following manner. The amount of CO_2 produced in a given time by a group of muscles is proportional to the amount of work they do, and the amount of work which a group of muscles is able to do without fatigue is proportional to the power of such group, that is to the number and size of the muscles composing the group. If, then, exercise is localised to a small group of muscles, fatigue will result before enough CO_2 had been produced to cause breathlessness; and if, on the other hand, nearly all the muscles of the body are used, the CO_2 produced will cause dyspnœa long before there is any fatigue.

We must all of us have noticed that in the breathlessness of exercise, expiration is short and difficult, whereas inspiration is long and easy. The following, I think, is the explanation of this. The first result of exercise is an increased velocity of the systemic blood current; this leads to pulmonary engorgement, thus there is a need for increased pulmonary blood flow. This can be brought about by deep inspiration, which, by filling the alveoli, squeezes the blood from the distended capillaries. Hence inspiration is an assistance to the circulation and so is easy of performance. On the other hand, as the intra-pulmonary pressure is lessened in expiration, blood tends to stagnate in the lungs during expiration, hence the prompt repetition of inspiration.

Dr. Lagrange divides the breathlessness of exertion into three stages. The first stage is one of mere augmentation of the movements, a balance being struck between the increased production of CO_2, and the increase of respiratory movements necessary to eliminate it. The amount of work which can be performed without passing into the next stage will, of course, depend on training, and on the power which the individual possesses of regulating his respiratory movements. The second stage commences when the production of CO_2 is greater than can be got rid of by the lungs. At first there is a feeling of general discomfort. Then there is a feeling of fulness in the head, buzzing in the ears, and later a dimming of consciousness, resulting in a confused idea of the surroundings. The mouth is widely opened and the nostrils dilated, in order to favour the entrance of the air which the lungs so greatly need. The cheeks become pale, and the lips and tip of the nose become dusky blue; the former being due to the fact that the heart becomes weaker from CO_2 poisoning, and so the arterioles are not properly filled; the latter to the distension of the veins with blood which is loaded with CO_2, and so of a dark blue colour. In this stage also the characteristic change in the rhythm of the respiratory movement occurs, inspiration becoming three times as long as expiration; and with this diminished expiration, the amount of CO_2 got rid of is more and more lessened, and the toxic symptoms more and more developed; the result being the third stage, when the respiratory distress gives place to a feeling of anguish; vertigo is distressing, the head feels as if bound by an iron band, the senses become vague, the brain is overcome by a kind of drunkenness, the muscles continue to act in an automatic manner, till finally consciousness is lost, and the individual falls down in a faint. Here also the type of respiration is again altered, both phases being short and jerky. When

exercise is carried to this extreme, it is always stopped by grave syncope, which has, Dr. Lagrange says, in several cases resulted fatally.

Besides these effects on the rate and rhythm of respiration, of course there are increased absorption of oxygen, and increased elimination of CO_2 and H_2O from the lungs. These, however, need no more than mere mention.

With regard to the urine, the effect of exercise is exceedingly slight, and it is only after long and violent muscular exercise that any change can be perceived at all. According to all observers, the water and sodium chloride are diminished, on account of the increased action on the part of the skin, and uric acid, sulphates, phosphates and pigment are increased. But concerning the effect of exercise on the excretion of urea, there is great difference of opinion, as shown by the following statements. In 1842, Simon and Lehman both came to the conclusion that the urea was increased by exercise. In 1855, Hammond experimented on himself, and with a constant diet found that walking twenty miles per diem nearly doubled the excretion of urea. In 1861, Dr. Smith made observations on prisoners working at the tread-wheel, and came to the following conclusions:—

1. When the tread-wheel is worked for a short period without food, there is no increase in that time.

2. With ordinary food, the increase is five per cent. of that passed on same food with light work.

3. With two diets varying in nitrogen, the amount of work remaining constant, the excretion of urea is greatest with the diet richest in nitrogen.

In 1866, in the well-known experiment of Fick and Wislecenus, the amount of urea was lessened, and the same was found by Rettenkofer and Voit. Two years later Dr. Parkes, experimenting on two soldiers, and Professor Haughton, experimenting on himself, both came to the conclusion that the effect was nil. Later, Flint in America, and Dr. Pavy in England, both made observations on the pedestrian Weston, and showed conclusively that continued severe exercise increased the excretion of urea out of all proportion to the nitrogen of the food, and also that the increase takes place to a great extent after the cessation of the exercise; and hence in moderate exercise, without subsequent observations, the increase may have been entirely overlooked. This may apply to Parkes' observations, but not to those of Haughton, who measured the urea for some days after the exercise. The more recent observations of North are perhaps the best yet recorded, for his diet was very carefully analysed during the whole experiment. He carefully analysed the urine during four days of rest, one day of work, when he walked 32 miles in seven hours, carrying a load of 28 pounds, and a further period of four days rest. The result showed a rise from 13·75 grms. of nitrogen during days of rest before the work, to 16·3 grms. during and after the exercise. He draws the following conclusions:—first, that severe exercise does increase the excretion of urea, but in the absence of nitrogenous food the increase is a small one; and secondly, that the amount of urea passed during any period is largely dependent on the nitrogenous constitution of the body for the time being, that is to say, it varies according as a greater or less reserve of nitrogenous material has been accumulated in the body. He adds, "It is quite possible that exercise may have a special effect in hurrying on the metabolism of such a reserve, and hence the point whether the nitrogen of the excreta is increased by exercise or not is determined by events, not so much in the muscles as in other tissues—the result being positive or negative, according as a large or small reserve is present, and according as that reserve is more or less labile."

The most important researches with regard to the effect of exercise on the temperature of the body are probably those of Dr. Clifford Allbutt. His observations were made on himself during a walking tour in Switzerland, during which a considerable amount of heavy work in the way of climbing was done. He used a very carefully-tested thermometer with an index, and observations were taken by keeping the instrument under the tongue whilst walking for fifteen to twenty minutes, and noting the time on removal. Of course, the effect of walking hard with a thermometer in the mouth was to increase greatly the amount of muscular work done, as anyone who has tried it must know full well. Before starting he carefully recorded the daily variations in his own temperature when he was not taking any excessive amount of exercise. An average of twenty-five days shows that the temperature was low on getting up in the morning, about 97·8, gradually rose during the day till six p.m., when it was generally 98·7, and then falling reached 97·5 at ten p.m. I will not weary you with the actual temperatures recorded during the thirteen days, but will give you a summary of the results. He found that the temperature was always raised while walking hard, reaching at twelve noon 99·2 about. Sometimes, when the day was begun earlier, the temperature would reach 99 by nine a.m. The temperature of about 99 was, as a rule, maintained till four to five p.m., and then fell gradually and reached 98 at about eight p.m. The conclusions drawn from these observations were that (1) the general tendency of exercise is to raise the temperature, not only at the climax, but also in the early part of the daily rise; (2) this rise was compensated for by the earlier occurrence of the evening fall, which had often reached the night level at eight p.m.; (3) weather had some slight influence. On hot days, whilst walking, 99·2 was invariably reached, whereas on cold or chilly days it commonly fell short of 99; (4) on one day, when an excessive amount of exercise was taken, the temperature fell quickly, and twice over during the day, as though the mechanical work was more than combustion could compensate. On this day, at ten a.m., while walking, the temperature was only 97·4; at eleven a.m., after a rest and some food, it was 99·2; at half-past one p.m. it had again fallen to 96·6; and at three p.m., while still walking, it was 95·5.

Another set of observations, by M. Lortet, carried out during two ascents of Mont Blanc, show a diametrically opposite result. He says, "While walking the decrease of the temperature of the body is very remarkable; it is almost proportional to the height at which one is. One may state that during a muscular effort, the body temperature may fall four or even six degrees centigrade —an enormous fall in mammals, whose temperature is said to be constant." Again, he says, "the moment one stops for a few minutes, the temperature quickly re-ascends almost to normal." The rest of his paper is occupied by the reasoning which attributes the fall of temperature to the transference of a given amount of heat to a given amount of muscular energy. He says that these results are not true for the hour following a meal, the presence of food in the stomach helping heat production, probably, he says, because the food "accelerates the capillary or general circulation." Unfortunately a page before he adduces the acceleration of the circulation through the lungs, in climbing, as a cause of cooling. Possibly the food in the stomach acted as a tonic and reflexly strengthened the heart-beat.

M. Lortet took a sphygmograph with him, and the tracings seem to show some serious interference with his circulation. The pulse seems to have been extremely rapid and small, and the arteries almost empty—in fact, they were the tracings of collapse. The tracings also show that the heart was very irregular at times.

Now, Dr. Allbutt states that his pulse was never irregular, and that it seldom reached 120 per minute during climbing. Judging from this, one cannot but think that there must have been some want of training or circulatory disease of some kind in Lortet producing the low temperature and the rapid irregular pulse, and this is borne out by the fact that on the one day when Dr. Allbutt was very fatigued his temperature fell whilst climbing as stated above. I believe, therefore, that the tendency of exercise is to bring about a slight rise in the temperature of the body.

(To be continued.)

Prizes.

THE ARTHUR DURHAM PRIZES FOR DISSECTION.

For Students in their Second and Later Years.

J. A. Glover, E. I. Spriggs, equal ... £7 10s. each.
J. O. Garland ... ... Certificate.
J. T. Roberts ... ... Certificate.

For Students in their First Year.

L. H. McGavin ... ... Prize, £5.
F. E. Walker ... . Certificate.

BEANEY PRIZE IN PATHOLOGY.

J. A. Howard... ... Prize £31 10s.
A. H. Leete ... ... Certificate of Honour.
E. A. Peters ... ... Do. do.
H. Davies ... ... Do. do.

Guy's Hospital Dental Society.

Some time since a general meeting of the Dental Students was convened to consider the advisability of establishing such a society as the above, and a provisional committee was formed to draw up a set of rules to be submitted to another general meeting for discussion.

On Thursday, the 15th instant, after some minor alterations, the following rules were unanimously adopted:—

1. The Society shall be called "The Guy's Hospital Dental Society."

2. The object of the Society shall be the consideration of matters generally and specially appertaining to Dental Science.

3. All members of the Staff, and Teachers in the School, and all present Students shall be eligible for membership, provided that they are already members of the Guy's Hospital Clubs' Union.

4. All past Dental Students of Guy's Hospital may join the Society on payment of the subscription of 5s., which shall entitle them to receive the transactions monthly by post.

5. The Committee shall have power to elect honorary members.

6. The management of the Society shall be vested in a committee elected annually at the general meeting, consisting of president, one or more vice-presidents, honorary secretary, treasurer, and two members in their first year (one each from May and October entry); two members in their second year (one each from May and October entry); one member irrespective of his year. Each entry shall elect their own representative.

7. The annual general meeting shall be held in May, to elect officers for the year, and to receive report and balance-sheet. A notice of such meeting shall be posted on the Conservation Room notice-board seven clear days previously.

8. At the written request of 10 members an extraordinary general meeting shall be called, such meeting to be held within 14 days of requisition; notice of such meeting, together with agenda sheet, shall be posted seven clear days previously.

9. The committee shall have power to suspend or expel any member who, in their judgment, is guilty of misconduct, provided always that the offending member may, within seven clear days of the notification of his suspension or expulsion, give notice of appeal to an extraordinary general meeting, which shall be forthwith summoned by the committee with the usual notice.

10. The meetings shall be held on the second Tuesday in each month, during the Winter Session, at 4.30 p.m.

11. The transactions shall be printed monthly, and each member of the Society shall receive a copy.

12. The committee shall have power to make bye-laws.

13. The annual subscription for present Students shall be 2s. 6d.

14. Members shall be permitted to introduce two visitors (not being Dental Students of the Hospital) to the meetings.

15. Visitors shall be allowed to take part in the discussions of the papers and clinical cases, but shall have no voice in the business of the Society.

16. All papers read at the meetings become the property of the Society.

17. The chairman of the evening shall regulate the proceedings of the Society; shall interpret the application of the rules, and shall decide all doubtful points that may arise.

18. On the evenings of Debates speeches shall be limited to ten minutes, except in the cases of the proposer and opposer, whose speeches shall be limited to 20 and 15 minutes respectively.

19. The Secretary shall record the transactions of the Society.

20. These rules shall not be altered except at a special general meeting called for that purpose.

21. A copy of these rules shall be given to every member.

The following officers were also elected for the ensuing year:—

President—F. Newland-Pedley, F.R.C.S., L.D.S.

Vice-Presidents—L. E. Shaw, M.D., J. H. Badcock, L.R.C.P., M.R.C.S., L.D.S., A. E. Baker, L.R.C.P., M.R.C.S., L.D.S., J. O. Butcher, L.D.S., J. Mansbridge, L.R.C.P., M.R.C.S., L.D.S., W. A. Maggs, L.R.C.P., M.R.C.S., L.D.S., H. Pillin, L,D.S., G. O. Richards, M.R.C.S., L.D.S., R. W. Rouw, L.R.C.P., M.R.C.S., L.D.S., H. Stoner, L.D.S.

Treasurer—M. F. Hopson, L.D.S.

Secretary—W. P. Wood, L.D.S.

Committee—E. R. Tebbitt, C. A. H. Keall, H. Wallis, J. W. Parr, M.D., C.M., U. E. Cave.

Short Sayings of Great Men.

I would rather have insanity in my family than be the son of a churchwarden.

I say, I am satisfied, that more than half the cases of acute glaucoma are treated as bilious attacks.

Ladies should remember that the breasts are meant for use and not for ornament.

Acknowledgments.

A Handbook of Medical Pathology, by W. P. Herringham, A. E. Garrod and W. J. Gow. London: Baillière, Tindal & Cox.

St. Bartholomew's Hospital Journal.

St. George's Hospital Gazette.

St. Thomas' Hospital Gazette.

The Hospital.

Notes from the Dispensary.

The Bacteriological Treatment of Typhoid Fever.

It would appear that we have entered into a new system of treatment of diseases, and that in time the Galenic preparations upon the shelves of the dispensary will be displaced by others, which have not been prepared in a pharmaceutical but in a bacteriological laboratory. There are actually in use at Guy's at the present time an extract of the thyroid gland and of the suprarenal capsule. Organic fluids, such as testicular and grey matter extracts, are advertised in the medical journals. The very latest *fin de siècle nouveauté médicale* is the treatment of typhoid fever by the hypodermic injections of cultures of the typhoid bacillus. Dr. Fraenkel has communicated to the Medical Society of Hamburg a very interesting note concerning the bacteriological treatment of typhoid fever. This treatment consists in making into the tissue of the gluteal region hypodermic injections of dead cultures of the typhoid bacillus, attenuated according to the method of Brieger, Kitasalo and Wasserman. By this method the bacillus is developed in a broth of the thymus gland of the calf, and it is killed by heating at a temperature of 60° C. The injections are not painful, and are not followed by any unpleasant reaction. At first 5 c.c. are injected, and repeated afterwards in doses of 1 c.c. according as the temperature of the patient becomes normal. Under the influence of these injections it is said that the fever can be completely controlled, and the general condition of the patient improves rapidly.

The same results have been obtained by Dr. Rumpf, who injected at first 5 c.c. and afterwards 1 c.c. of the dead culture of the Bacille Pyocanique attenuated by the same method.—*Répertoire de Pharmacie, Février 10, 1894.*

Pil. Opii. gr. i.

Considerable discussion has lately taken place in the pharmaceutical papers and at evening meetings as to what a prescriber intends when he writes Pil. Opii. gr. i. in a prescription. In Guy's Pharmacopœia it can be seen that Pil. Opii. is given as a synonym of Pil. Saponis Comp. P.B.; a dispenser following the Pharmacopœia would for Pil. Opii. gr. i. give Pil. Saponis Comp. gr. i., which is equal to about one-fifth of a grain of opium. At Guy's, Pil. Opii. gr. i. is always written upon the bed-letters, and this is considered by the dispensers to mean one grain of opium in a pill. It would be well to note that the correct way of ordering one grain of opium in a pill is to write, not Pil. Opii. gr. i., but *Pulv.* Opii. gr. i. in forma pilula.

Emp. Lyttæ.

I am frequently asked: What is Emp. Lyttæ? It cannot be found in the Pharmacopœia, nor is it mentioned in any of the text-books of Materia Medica. It certainly is a very curious fact that Guy's, so progressive in all things, should still cling to this obsolete word, and that successive generations of ward clerks are told

to write Emp. Lyttœ. when a blister is required. I do not think there can be any one at Guy's so old as to be able to say that he remembers Emp. Lyttœ. as a pharmacopœial name. H. COLLIER.

Appointments.

The following appointments have been made by the Treasurer:—

House-Physicians.—Mr. A. J. Sharp (Dr. Pye-Smith); Mr. J. A. Howard (Dr. Hale White).

House-Surgeons.—Mr. W. J. Johnson (Mr. Howse); Mr. J. B. Leathes (Mr. Davies-Colley).

Assistant House-Physicians.—Messrs. L. Slater and A. Chaning-Pearce.

Assistant House-Surgeons.—Messrs. G. Lawrence and W. Poole.

Resident Obstetrics.—Messrs. H. M. Stewart (April); H. Cooper (May); V. Pendred (June).

The following appointments have been recommended by the Medical Council, and approved by the Treasurer:—

Clinical Assistants.—Messrs. H. A. Duffett, G. E. Manning, E. A. Peters, E. F. H. Hardenberg, H. Davies, C. L. Hopkins.

Dressers in the Eye Wards.—Messrs. H. W. Beach, J. J. Coleman (Mr. Higgens), (May); C. E. Carpmael, H. W. Collier (Mr. Brailey), (May).

Surgeons' Dressers.—Messrs. G. L. Eastes, J. G. O. Lane, B. W. M. A. Key, J. W. Bird, T. H. B. Yorath, H. R. T. Fort (Mr. Howse); H. Pern, E. T. Shorland, M. P. Jones, A. V. Clarke, C. A. Trouncer, W. A. Carden (Mr. Davies-Colley); F. J. Steward, B. A. Richmond, W. G. Mumford, W. S. Handley, H. A. Moffat, A. A. H. Partridge (Mr. Lucas); P. R. Lowe, C. H. Bryant, D. W. Thomas, H. Nolan, W. F. Byford, G. Gocher (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. H. Fulham Turner, T. M. Thomas, H. P. Ferraby, W. C. C. Pakes, R. O. Moon, R. Mathias (Mr. Jacobson); W. L. Garner, M. H. Smith, C. W. Booker, G. E. Duncan, E. N. Scott, T. B. Poole (Mr. Symonds); E. Coleman, H. E. Izard, R. Hedden, E. A. Prebble, T. J. A. Tulk-Hart, E. T. Scowby (Mr. Lane); H. M. Wise, R. T. Brown, W. J. Henson, E. R. Thomas, H. S. Desprez, P. G. Temple (Mr. Dunn).

Medical Ward Clerks.—Messrs. C. J. Harnett, H. J. Spon, J. Hora, W. J. Rowland, P. E. Tresidder, R. H. Ashwin, N. Daly, R. E. Delbruck, P. H. Haylett, C. D. Edwards, B. B. Ham, G. B. Muriel, W. Tyson, F. J. H. Cann, W. Ramsden, W. L. Stuart, A. J. Dolman, F. W. Rowland, T. L. Jackson, W. A. Horton, J. Robertson, H. Alexander, G. F. Birdwood, C. G. Burton, C. Coventry, P. J. Curtis, W. W. Farnfield, F. A. Godson, F. H. Hardy, S. G. Layman, L. C. Panting, A. S. J. Pearse, J. C. G. Reed, T. W. Stanton, C. C. Stead, C. E. S. Watson.

Assistant Physicians' Clerks.—Messrs. B. P. O'Neill, E. H. Tipper, W. C. P. Winter, E. J. Maxwell (Dr. Pitt); F. R. Proctor-Sims, P. N. Vellacott, L. Worts, A. H. H. Huckle (Dr. Shaw); A. Scott-Turner, O. Beven, R. F. Clark, B. F. Pendred (Dr. Washbourn).

Aural Surgeon's Dresser.—Mr. A. E. Philipps (May and June).

Dental Surgeons' Dressers.—Messrs. L. A. Parry (April and May); A. J. Collis (May and June); A. C. Fry (June and July).

Dressers in the Throat Department.—Messrs. F. S. Brereton, J. H. Horton, H. A. Munro, B. G. Reynolds.

Post-mortem Clerks.—Messrs. J. C. Constable, J. J. Foster (May and June); A. P. Beddard, E. E. Henderson (June and July).

Obstetric Ward Clerks.—Messrs. R. H. Hayes, W. C. Pitt, P. E. Tresidder.

Obstetric Out-Patient Clerks.—Messrs. J. R. Steinhauser (1st half), C. Beadnell.

Surgical Ward Clerks.—Messrs. C. C. A. Salmon, B. Instone, F. Golding-Bird, E. D. Hancock, N. Y. Lower, J. B. Parfitt, A. H. Spicer, J. O. Garland, J. A. Glover, M. C. Hayward.

Assistant Surgeons' Clerks.—Messrs. H. Cardin (Mr. Symonds); G. B. Webb, W. R. Wood (Mr. Jacobson).

Clerks in the Skin Department.—Messrs. C. B. Statham, A. H. Leete.

Dental Appointments.

The following Dental appointments have been recommended by the Dental Committee and approved by the Treasurer:—

Dental House-Surgeon.—Mr. S. Keele (till Sept. 30th, 1894).

Assistant Dental House-Surgeon.—Mr. F. C. Constant (till Sept. 30th, 1894).

Demonstrators in Conservation Room.—Messrs. W. E. Hills, W. H. Trick, D. S. Stevens (till Sept. 30th, 1894); A. J. Collett (till June 30th, 1894).

Curator of Laboratory.—Mr. C. A. H. Keall (till Sept. 30th, 1894).

Dressers in the Gas Room.—Messrs. A. L. Allworth, O. Armer, C. H. Charter, A. B. Ryle (for April).

Dressers in the Ordinary Extraction Room.—Messrs. E. Ashby, N. Denham, J. L. Payne, A. Read, B. B. Westlake (for April).

Recent Additions to the Library of the Students' Club.

Many Inventions.	R. Kipling.
Life's Handicap.	Do.
Wee Willie Winkie.	Do.
The Light that Failed.	Do.
Moore's Modern Painting.	
Catriona.	Stevenson.
The Wrecker.	Stevenson.

Passim.

All those who were fortunate enough to be present in the Anatomical Theatre on Wednesday last will not readily forget it. The occasion was that of the last clinical lecture of Mr. Durham, a résumé of which will be found on the first pages of this issue. That the theatre was crowded almost to its utmost goes without saying, and the kindly words of counsel and advice offered by the lecturer as clinical aids, were listened to with the keenest appreciation. Mr. Durham's numerous references to Guy's aroused patriotic feelings in all of us, and his encouraging words on behalf of the Guy's Hospital Gazette were duly noted by the editors. The reference made to a list of the interesting cases to be inserted in the columns of the Gazette as aids to the student, touched a point which has been troubling us for some time, as frequent notices in our columns will testify. It has been found, from some reason or another, that the ward clerks, or others deputed for the office, do not always send in to the Gazette a list which possesses sufficient completeness or sense of proportion in the way of selection. Accordingly, in our next issue we hope to publish, with the kindly assistance of the house-surgeons and physicians, a "Ward Column," to serve as a model for future reference. By this means the value of the Gazette as a clinical teacher will, we trust, be considerably enhanced.

Leave-takings are often memorable rather for the amount of sentimentality expressed on the occasion, than for the recollection of the many happy moments spent together in the lives of friends. At the best of times, they are always associated with feelings of regret and sorrow that the grand old times will come no more. Anything more affectionate and considerate than the final words of Mr. Durham in the Anatomical Theatre it would be impossible to conceive, the memory of them will live hand in hand with the memory of the speaker, characteristic of the great man and of his great work, for many a long day among Guy's men. At the conclusion of the lecture the whole body of students rose to their feet, and expressed their respect and affection in a prolonged outburst of impressive applause.

Owing to the issue of the Gazette this instead of last week, we are only able to give notice on the morning of the day which has been arranged for the dinner to Mr. Durham, that the affair is not restricted to members of the "old firm," but any Guy's man, past or present, is invited to attend. Tickets may be obtained of Messrs. R. H. Fagge and T. M. Nicholson, price 10s. 6d. The dinner is to be held at the St. James's Restaurant, at 7.30 p.m., Mr. Jacobson having kindly consented to occupy the chair.

We are glad of the opportunity to direct attention to the recommencement of Notes on Dr. Shaw's Pathological Demonstrations in this issue. They are the continuation of the notes which appeared some time back, and we purpose to make a complete series.

The last meeting of the Pupils' Physical Society was held on Saturday week, the President, Dr. Wilks, with his usual kindness, occupying the chair. The Treasurer's Prize Essay on the "Pathogenesis of Morbid Growths," was read by Mr. D. M. Beddoe, who wins the Treasurer's Prize of £5, after which an excellent discussion took place. The other prizes were awarded as follows:—Messrs. F. J. Steward and C. J. Harnett divide the prize of £10 awarded for the best papers read during the session, and Mr. G. F. Still receives the Senior Debating Prize of £4. The list of officers elected for the

ensuing season, we shall endeavour to publish in our next issue, when a more detailed account will be given of the evening's proceedings.

The Lady Superintendent of the Nursing Institution wishes us to state that she will be most glad to receive—for the purposes of the Charity—any article of male attire which our readers may happen to have no further use for. The demand for such material is very great just now. The Report of the Institution is most interesting reading this year, and will be fully reproduced in our next issue.

The Annual General Meeting of the Students' Club for the Election of Committee and other business, will be held on Thursday afternoon, May 3rd, at four o'clock, in the Anatomical Theatre. The meeting should have been held in March, but Easter was upon us so early this year that it was found impossible to obtain a convenient day at the end of the Winter Session. In view of the increased interest manifested during the past Session in the affairs of the Club, which indeed is the most important minister to our wants and comforts of all the Institutions at Guy's, it is devoutly to be hoped that members will attend in force and see to it that the right men are chosen to represent them on the Committee.

The Residents' Annual Dance, held through the kindness of the Treasurer in the Governors' Court Room, proved a most enjoyable affair. In the enforced absence of Mrs. Lushington, Mrs. Taylor and Mrs. Howse kindly received the guests, who numbered about 120. The music was excellent; all the arrangements were admirably carried out by the indefatigable M.C., Mr. Cooper, who was ably assisted by the other Residents acting as stewards. Dancing was carried on till about 12 o'clock, and save for occasional slight crowding, left nothing to be desired. A large number of the Staff were present, amongst the company being Dr. and Mrs. Taylor, Dr. and Mrs. Galabin, Dr. and Mrs. Newton Pitt, Dr. and Mrs. Perry, Dr. and Mrs. Stevenson, Mr. and Mrs. Howes, Mr. and Mrs. Davies-Colley, Dr. Horrocks, Mr. Lane, Mr. and Mrs. Symonds, Mr. and Mrs. Tubby, Dr. Bryant, and a number of old Guy's men.

To all those interested in Opera Bouffe, it is worth noting that a new and original Comic Opera, entitled "The Buccaneers," is to be produced at the Town Hall, Streatham, during the second week of April, in aid of a local charity, in which three or four Guyites are taking a prominent part. We learn that Mr. B. F. Pendred and Miss Glazier are responsible for the music, while Mr. L. St. L. Pendred is the librettist. Those taking part from Guy's are Messrs. V. Pendred, B. F. Pendred, J. E. Coulson, and H. J. Spon.

Another much coveted trophy, in the shape of the United Hospitals' Association Football Challenge Cup, has been added to the club as a further evidence of the eminence to which Guy's has attained in the world of sport. It is the fortunate lot of few teams to play right through a competition without a reverse, thus incontestably showing their right to be holders of the Cup. But seldom indeed does a team, suffering defeat in the first round as ours did, finally win the Cup—under such curious circumstances which attended the United Hospitals' competition this year.

It will be remembered how, Guy's having suffered defeat at the hands of St. Mary's, St. Bartholomew's, who were to meet the winners in the next round, lodged an objection against one of the St. Mary's men, who was found to be out of his year—an objection made valid by the

United Hospitals' Committee. St. Mary's in a most sportsmanlike manner, however, offered to re-play their tie with us with a legitimate eleven the result being a most gratifying and satisfactory one for Guy's.

While offering, then, the Guy's eleven our heartiest congratulations for their splendid performances throughout the season—particularly in the Surrey Cup ties, in the final of which we again meet Reigate Priory to-day—Guy's men must not lose sight of the generous action of the St. Mary's eleven, which has enabled us to win once again the United Hospitals' Challenge Cup. Long may we keep it!

It gives us great pleasure to add our congratulations to the many at present heaped upon the head of Mr. Hewetson, the captain of the eleven which has again brought back the Association Cup to our midst.

The Walton Football Club Secretary has in last week's *Surrey Advertiser* contradicted many of the false statements given as reasons for the Weybridge downfall—now a matter of history, and he no doubt gives expression to what is the general opinion, that on the day the best team won; he also declares that A. B. Carter's display at back was one of the finest exhibitions ever seen on the Walton ground. Bravo Walton!

The Rugby Football season terminated with a drawn match against Richmond, and, though we cannot point with enthusiasm to the "Blue-ribbon" of the Hospital trophies, we can, at least, think with pride of the splendid struggles that have always characterised our matches with St. Thomas's in the Cup ties, feeling sure that the excellent play and good-fellowship of the fifteen must bear its fruit in the future. The second eleven and fifteen are, we understand, also to be congratulated on successful seasons, though no details are yet to hand. What has become of the third fifteen so auspiciously started two seasons ago? We should be glad to hear something of their doings.

We purpose, at no distant date, giving an account of the doings of the teams during the past season, with, we hope, photos of some of our very excellent players. Meanwhile, we can only wish them the best of luck, and a well-deserved win in their Reigate tie to-day, and condole with ourselves on the loss we shall sustain next season, when Hewetson, Daniel and Hibbard will no longer be allowed to represent the Hospital as they have done so often and so ably before.

Latterly we have heard of complaints about the condition of the ground at Brockley, but we are assured, upon enquiry, that operations upon it have been delayed for obvious reasons. Harris—to whom we wish a speedy recovery—has been ill with scarlet fever; the temporary ground-man is hardly *au fait* with the working of the ground, and the Clubs' Union horse has been returned, after a winter of (?) rest—*lame* and unfit for work. In spite of this delay, however, the Council have already taken steps towards the preparation of the ground for cricket and tennis, rolling having already commenced this week. Plenty of good work will be needed now, to make the ground fit for the number of matches that are to be played on it during the coming season—an undertaking we are sure the Council are quite prepared for, and of which no reminder is necessary.

We are glad to note that an Inter-Hospital Cycling Association has been successfully formed. We hope to have details from the secretary before our next issue.

A Visit to Leper Settlement at Robben Island.

PERHAPS an account of a visit to the above island may be interesting to the readers of the GAZETTE.

Although I have made four voyages to the Cape in the mail service of the Castle Company, it was only during the last trip that the ship docked in time for me to catch the Government tender to the island. The tender leaves twice a week, and it is necessary to obtain a visiting order at the Colonial Office, Cape Town, some days in advance, for which a nominal charge of 2s. return fare is required. I believe that relatives of patients are taken gratis. A friend kindly obtained a pass for Dr. Anderson, also a surgeon in the Currie line, and myself. We found our little packet moored to the quay; from the latter to the former the stores for the island were being rapidly transferred. At length we were permitted to embark, the visitors consisting of whites, Malays and half-castes, and very picturesque the Malays looked in their gaudy coloured clothing.

The journey to the island occupies about an hour, across Table Bay, and our little craft did a fair amount of rolling, although the sea was perfectly smooth, and some of the passengers looked very unhappy, and I dare say felt so, too.

At about 11 a.m. we arrived off the island and anchored, as there is no quay or landing stage of any kind. After a little delay, two boats put off from the shore, manned by convicts, a warder being in command of each. The white passengers disembarked in the first, followed by the dusky visitors in the second. Our boat was beached as high upon the shore as possible, and the ladies were conveyed to terra firma upon chairs arranged on stretchers carried by two convicts. The males of the party reached the shore riding pick-a-back—a most anxious and undignified five minutes—for as one leaves the boat you sway forwards upon the nigger's shoulders and fancy you are taking a header into three feet of water.

Robben Island is about three miles in circumference, inhabited by lepers, lunatics and convicts, with their attendants, medical officers, not forgetting the light-house keepers; is perfectly barren, dried grass here and there, but mostly sand, which is very trying to the eyes when the sun is shining upon it. Upon landing we at once sent in our cards to Dr. Impey, the senior resident medical officer, who saw us at once, and from whom we experienced great kindness and courtesy. He regretted that for an hour or two he would be unable to join us, as on visiting days his work was necessarily heavy, he having virtually charge of the island and its population —a semi-official position which entails a great deal of work—but hoped, in the meantime, we might find the leper wards interesting, giving us the necessary letter of introduction to his subordinates.

The day was very hot; overhead the beautiful blue sky of South Africa, happily there was no wind.

The leper settlement is about 1½ miles from the landing place. On arriving there we were not only hot, but our eyes smarted considerably from the glare around us.

The leper male wards are built in blocks, with about 150 to 200 yards between each. The female settlement is constructed upon the same plan, is some distance from that belonging to the other sex, and is enclosed by a high wall. Each ward has a stoop which protects the patients from the sun; is lofty and well ventilated. The sanitary and culinary arrangements are good. The lepers who are able help in the general work of the ward, and attend upon others less fortunate. There are about 600 lepers, male and female—blacks and whites; the latter in both locations have a ward to themselves.

The three kinds of leprosy are well marked—tubercular, anæsthetic, and mixed. Dr. Impey classifies a fourth variety—syphilitic leprosy, in which the leprosy is modified by the syphilis. We noticed that most of the tuberculous patients had laryngeal trouble, which we were told they get quite early in the disease. The face suffers more in proportion in this form than other parts of the skin, and the term "leonosis" is not misplaced, for the face swells enormously, the tubercules are soft and semi-diffluent to the touch, and apparently painless, as manipulation causes no inconvenience. In some of the worst cases the face is very much disfigured, the nose and eyes in two patients having disappeared, leaving an ulcerated surface.

In the later stages the body wastes extremely, and towards the end the thermic centres seem to become affected. The temperature is very erratic. Death in this variety of leprosy takes place, according to the experience of Dr. Impey, within eight years from first symptoms. Inter-current diseases, especially phthisis, carries off a certain proportion of cases.

In anæsthetic leprosy life is often prolonged to twenty years. In this form the first symptoms complained of are, for example, an anæsthetic area over one of the phalanges, followed by shooting pains in the course of the main trunk of the nerve up the arm (this pain in some cases is agonising) and rise of temperature, which subsides after some days. The bone necroses, and eventually, if untreated, the skin sloughs, the bone comes away by suppuration, leaving an ulcerated surface which heals by granulation. After a variable lapse of time a toe is attacked, another phalanx or the tibia, and the same course of symptoms is gone through, with ultimate loss of some bone or the entire member.

One case showed the loss of the carpal bones of each hand and the tarsal bones of each foot. The parts were well nourished and hanging like flails, connected to the arms and legs respectively by skin tendons, etc. In this patient the bones, as necrosis took place, were removed by operation.

The patients are very clever in using their stumps in performing the daily duties of life, and are cheerful, considering the monotony and hopelessness of their lives.

The treatment of leprosy in its various forms is at present entirely palliative. Much may be done to relieve the shooting pains of the anæsthetic form, and by operation and early removal of necrosed bones, much suppuration may be saved, and the patient's general health improved, more especially as in the anæsthetic area the operation is painless, so that chloroform is not required.

Dr. Impey, who is a most zealous officer, is working hard at the pathology of the disease; he finds lepra-bacilli in great abundance in the tuberculous tissue, and the converse in the nerve, etc., of anæsthetic leprosy; he believes the disease to be contagious only through inoculation from a leper. An attack of measles profoundly modifies the course of the disease, delaying its progress for years, and our guide hopes that some advantage of the antagonism evidently existing between the two varieties of germs may be gained in the treatment of this loathsome disease.

We had just done the lunatic wards, and were about to join the doctor in a cup of tea, when a prolonged whistle from our little packet warned us to return beachward, so, bidding our friend a long farewell at the place of embarkation—for he insisted on seeing the last of us—we rejoined our tender, and reached Cape Town in good time for dinner, having spent a most interesting and enjoyable day.

H. KNIGHT RAYSON.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Diabetes Mellitus in a Boy.

DEAR SIR,—The interesting report of a case of Diabetes Mellitus in a little boy, mentioned in your last issue, brings to my recollection a similar case which I saw three years ago when Assistant House-Physician, which may be of interest also. The patient, a boy 3½ years of age, was brought in complaining of constant thirst, the mother noticing that he was always drinking. He had lost flesh, and the tongue was very red and uncomfortable. On examining the urine, it was found to be clear, pale, of high specific gravity, and to give an abundant brick-red deposit with Pavy's solution on heating. I showed the case to Dr. Shaw, who was seeing out-patients, and tried to induce his mother to allow him to remain, but she would not, and I never saw him again.—Yours sincerely, H. W. WEBBER.

Diuretic Diuretin in Dropsy.

SIR,—In reading the Clinical Lecture on "Dropsy" in the GAZETTE of March 10th, I was struck by the absence from it of all reference to the new Diuretic Diuretin.

The following short notes of a case recently treated by this new remedy may therefore be *apropos*:—

G. F., aged 47. Groom. History of dyspnœa on exertion, and gradually increasing anasarca in the last four years.

On February 1st he measured 42 inches round the abdomen, and was in much distress. The question arose, should I then tap him, or insert a Southey's trocar, or try Diuretin. I decided upon the last. I gave him 10 grains 3 times a day. Result:—

February	3	... ...	41 inches.
"	4	... ...	40 "
"	5	... ...	39 "
"	12	... ...	37 "
"	23	... ...	35½ "
March	6	... ...	34 "
"	16	... ...	32½ "

In addition to this great reduction round the waist, there was going on at the same time a like reduction in the size of the legs, so that from being intensely œdematous they have now become quite normal in appearance. Before this, digitalis, strophanthin, and all the usual diuretics and purgatives had been used, but had seemed to have lost their effect upon him, and he was gradually getting water-logged. The cause of the dropsy was mitral regurgitant disease.—I am, Sir, yours truly,

T. REUEL ATKINSON.

Review.

Ibsen.—A Lecture delivered at University College, Liverpool. By Sir Edward Russell. London: Simpkin, Marshall & Co.

In this little book Sir Edward Russell has put before the public a work of some value, a critical study of the works of the Norwegian dramatist dealt with in a pithy and interesting manner. To our friends, those admirers of Ibsen who unceasingly hold discussions in our midst, this book may contain nothing new; but the average man, in state unemancipated, marvelling at Ibsen's art and doctrine, will find the Liverpool lecture interesting. Our critic is evidently what the admirers of the good old Adelphi business would scornfully term "an Ibsenite;" for, on his first page, he remarks on the opposition offered to Shakespeare, Beethoven, Darwin and Wagner, and that met with by the Author of Ghosts, and boldly urges that Ibsen like them will defy extinction. Sir Edward goes on to deal with the antagonism of "the profession," to wit, the playactors, and we can only regret that he does not deal more fully with these "happy, healthy, and wholesome personages." Our critic is, however, not all praise, for further on we read that Ibsen is "provincial and juvenile." On both these points we must respectfully differ. In the first place, we consider that an author may legitimately employ homely people, talking of the

common things of their little world, without being reproachfully regarded as provincial—provided that in so employing these persons the author unveils human nature, or demonstrates some great principle. Nor can we agree that Ibsen is juvenile—certainly he has never struck us as "a very young gentleman," but rather as one who, if possible, knows too much. In translation, Ibsen is at times certainly crude, and this is, perhaps, a fault even in the original text; but, as Sir Edward remarks—"his faults and awkwardnesses matter not,"—so huge is he, "so powerful is his grip." The book contains excellent short comments and descriptions of the plays, but again we must take exception to what our critic says concerning "Peer Gynt,"—"a more vulgar master builder." Certainly, in this play, if at all, "the certain awkwardnesses should not matter," "and the pure poetry of the thing should carry us past all obscurities." We differ, too, about certain remarks on Rosmersholm; for we do not consider the dogmatic formalities of Rector Kroll, nor the actions of the low-minded editor mere "parochial pettishness;" indeed, we hailed both personages as people we had met before on the broad stage of mother earth. We were, however, delighted with Sir Edward Russell, and not shocked with Mr. Clement Scott, when Nora Helmer banged the street door of "the Doll's House;" we were even so improper as to let our sympathy go out to her, and not to her deserted husband. We can only regret that the time to which a lecturer is necessarily limited evidently prevented Sir Edward giving us his views of "The Vikings," "Lady Niger," and some other plays.

Pavy Gymnasium.

The fourth annual gymnastic competition was held in the Gymnasium on the 15th instant. Besides the usual gymnastic display, the first fencing competition also took place. The evening will be memorable as being the first occasion on which ladies have been present as guests in the Gymnasium, a number of the fair sex being invited, including the Matron and Sisters of the nursing staff, a goodly number of whom attended. Proceedings began at eight o'clock with exercises on the horizontal and parallel bars, followed by the first round of the fencing competition. Then followed a short interval, during which refreshments, provided in the dining hall, were much appreciated. The second half included the remainder of the gymnastics—*i.e.*, exercises on the rings, horse, and the rope—and the semi-final and final rounds of the fencing, some of the bouts being very exciting. Dr. Pavy, with his usual kindness, presided and distributed the prizes. At the conclusion, Mr. Spon, to whose untiring energy as honorary secretary the whole of the arrangement of a most successful evening was due, proposed three cheers for Dr. Pavy, which were heartily rendered. Dr. Pavy in expressing his great pleasure in witnessing and presiding at the entertainment, also expressed his regret that Mr. Durham was unavoidably prevented from being present. After three cheers had been given for the ladies, followed by three for the Staff, which was represented by Messrs. Dunn and Fripp and Dr. Fawcett, a most enjoyable evening was brought to a close. Mr. F. S. Brereton and Staff-Sergeant C. F. Young, of the Chelsea Barracks, kindly officiated as judges. Details:—

FENCING COMPETITION.

First Round.

A. J. Howe beat C. E. Michael, the former, fencing in a style rather characteristic of the single-stick than of the School Italian, managed to win by 3 to 2, though with a little more luck Michael should have had the best of the bout.

E. T. Jensen beat E. A. Peters.—Peters, not fencing in anything like his real form, suffered defeat in a somewhat unexpected manner at the hands of his tricky opponent by 3 to 2.

G. E. Duncan beat E. E. Henderson.—This was an interesting bout. Henderson, doing all the attacking, gained the first two hits, and then Duncan, settling down into good form, gained the next three, and was returned the winner.

A. Scott-Turner beat H. J. Spon.—The latter was no match for his more experienced opponent, and though given several easy opportunities of scoring, failed to get in more than once, and Scott-Turner, taking things pretty easily throughout, won by 3 to 1.

Semi-Finals.

G. E. Duncan beat A. J. Howe.—Exchanges were frequent and exciting, and when "two all" had been called Duncan appeared to go out of the ring, but the appeal to the referee was not given. The forcing tactics of Howe did not avail, as try as he would he was unable to get on the shield, and a clever return of Duncan gave him the victory of a well-contested bout by 3 to 2.

A. Scott-Turner beat E. T. Jensen.—Scott-Turner, having all the best of matters with his smaller opponent, ran out an easy winner by 3 to 0.

Final.

A. Scott-Turner beat G. E. Duncan.—Duncan drew first blood, but Scott-Turner, waking up, put in some very pretty and sharp work, and scored rapidly. His opponent was defending well, but was unable to score again, and Turner, gaining 5 to 1, was returned the winner of the competition, Duncan gaining second prize.

GYMNASTIC COMPETITION.

The scoring has not reached us, but we are able to give the names of the squads, which numbered three of four competitors each, a good entry, but not so large as should be in the competitions of such an excellent institution as the Pavy Gymnasium. The winning squad consisted of Messrs. H. J. Spon (leader), N. H. Pike, E. I. Spriggs and B. G. Reynolds, none of whom have

won a prize in the competitions before. The others consisted of Messrs. R. Sergeant (leader) J. Richardson, K. B. Alexander and S. Copley, and H. Walling (leader), C. T. Anderson, C. H. Bryant and H. A. Moffatt. The first three places were taken by Messrs. Spon, Walling, and Richardson respectively, all of whom were close up. Walling, who had been unwell for a day or two, was hardly up to his form, and Richardson is new yet to the work, and will do more in the future. The form shown, on the whole, was creditable to the instructor, Sergt. Roche, but members cannot expect to do much in gymnastics without plenty of frequent and regular practice, a fact which it is surprising so few Guy's men seem to appreciate.

The Committee of the Pavy Gymnasium desire to express their thanks on behalf of the Club to the donors of prizes for the recent competitions. They were, Dr. Pavy, Gymnastic Competition; "An Old Guy's Man," for special prizes in Fencing, Boxing, and Gymnastics; and Mr. G. A. Skinner for Boxing.

Appointments.

Chilton, H., L.R.C.P. Lond., M.R.C.S., has been appointed House-Surgeon to the Tiverton Infirmary, *vice* Michelmore, resigned.

Cuff, Robert, M.B. Lond., M.R.C.S., has been appointed Medical Examiner of Recruits for the Yorkshire Artillery Militia, *vice* Wright, retired.

Farr, E. A., L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Medical Officer of the First District of the Andover Union.

Makepeace, A. J., L.D.S., R.C.S., has been appointed Honorary Dental Surgeon to the Coventry and Warwickshire Hospital.

Symonds, C. P., M.R.C.S. Eng., L.S.A., has been appointed Medical Officer to the Lathom Local Board.

Turner, George, M.B. Cantab., D.P.H., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health for Bishop Stortford.

In our issue of the 10th ult. we noted the appointment of Drs. J. C. Uhthoff and C. J. Oldham to the Sussex Eye Hospital. We since learn that these gentlemen have held office fourteen and twenty years respectively, and we much regret any annoyance caused to them by having represented their appointment as a recent affair. Our source of information was one usually found trustworthy.

Calendar of Coming Events.

Mar. 31st.—Guy's Hospital v. Reigate Priory, at Guildford. Final Tie, Surrey Cup Competition. Kick-off at 4.15 p.m.

Dinner to Mr. Durham at St. James's Restaurant, 7.30 p.m.

Sport.

Association Football.

UNITED HOSPITALS ASSOCIATION FOOTBALL CHALLENGE CUP.

Semi-Final Tie.

GUY'S v. UNIVERSITY COLLEGE.

Pleasant spring weather favoured us on Wednesday, when we met University College Hospital at the Essex County Ground at Leyton, to decide who should oppose Middlesex in the final tie. Some five or six hundred spectators, of whom by far the larger number were students, witnessed a fast and determined game from start to finish. The ground was in capital condition, and at about 3.15, Guy's kicked off against the sun and a slight breeze.

We had much the best of the play, and immediately after the start, we commenced attacking our opponent's goal, and should have scored more than once but for ineffectual shooting. At the arrival of half-time neither side had scored.

Immediately after the interval, our right wing took the ball down, and passed across to Hewetson, who scored our first goal. We again returned to the attack and kept Marles-Thomas well employed, who, however, was equal to the occasion for some time, until at last Hibbard beat him, and placed us two goals to the good. From this point of the game, except for an occasional break away by University, we gave Thomas no rest. However, two or three minutes before time a dashing run by the University left wing and centre resulted in Barwell scoring their only point, thus leaving us the winners by two goals to one.

Ours was undoubtedly the better team, and, had we played up to form, should have won by a much larger margin, for the score in no way represented the game. The teams were:—

Guy's.—N. Lavers (goal); F. J. Lidderdale and A. B. Carter (backs); A. M. Daniel, N. C. Cooper and A. E. Crosby (half-backs); F. E. Walker and C. E. Hibbard (right wing); R. T. Fitz-Hugh (centre); R. B. Stamford and H. Hewetson (captain) (left wing).

University.—T. Marles-Thomas (goal); M. Clover and A. Hunnard (backs); G. W. Gostling, G. B. Hunt and F. B. Carter (half-backs); C. M. Ekins and W. H. Agar (right); F. R. Barwell (centre); H. Boam and T. H. R. Bucknall (left).

Final Tie.

GUY'S v. MIDDLESEX.

Probably the number of men journeying from Guy's to Leyton on Wednesday the 21st to witness this match neared one hundred, and formed by far the larger fraction of the spectators.

The team, which differed in only one instance from that opposed to University in the semi-final—Humphry replacing Walker, who was hurt, showed their true Leyton form, which everyone knows to be villainous, and gained by no means such an easy victory as was expected, the reason for which was found in general slackness and bad shooting.

The start, fixed for three o'clock, was delayed twenty minutes owing to the non-arrival of one of our opponents, when Fitz-Hugh, having lost the toss, kicked off towards the Pavilion goal with a slight wind assisting him, but the sun in his eyes. The ball was immediately passed out on the left wing, and Humphry, centreing well, enabled Stamford, with a fast shot, to notch our first point. On the ball being again set in motion, even play followed for a time, until Humphry was given off-side when looking dangerous. Lavers now had to catch a dropping shot from Ellery and throw away, and play returned to their lines, where Fitz-Hugh shot into their custodian's hands, and again, soon, the same player shot wide when quite under the posts, after Hewetson had failed to get the ball past their goal-keeper.

Guy's then had some trouble in checking the runs of their forwards, Cooper and Daniel doing good defensive work, but just before half-time Hibbard had hard luck in not scoring from a very hot shot, which hit the cross-bar and returned into play.

The second half opened with a corner to Middlesex and an anxious time for us, but Lavers saved his charge well in his best style from three dangerous shots. These attacks awakened our forwards, and Stamford, after a combined run, beat their goal-keeper for the second time with a low shot. But our opponents would not be denied, and the previous desire to sleep on the part of our men having increased after the rousing, the game was chiefly carried on in our territory, until Ellery beat Lavers with a high shot, which came back off the net, and was thought at first by some not to have scored.

Play now became of a more interesting character, as the Guy's forwards, after the repeated appeals of the spectators to "buck up," gradually gained ground, and after a poor shot by Stamford, Fitz-Hugh finished up a fine run by scoring our third goal. The game now appeared to be all over—bar the shouting, for Middlesex, except for individual bursts, well nipped in the bud by our backs, were quite outplayed, and we must have chalked up a large score had not Stamford and Hibbard shown entire inability to send the ball into the net, although each scored a goal when given off-side; the latter, however, with a fine shot notched our last point, and we had won the cup after six years' interval by the useful score of four goals to one. Our team were undoubtedly the better side, if we except their intervals of slackness, and our backs all played well at times, although Cooper was, after fifteen minutes' play, hindered by a return of the lameness which had kept him out of the first Reigate match. Lavers deserves a special word of mention for good play at a critical point in the game, as his defence was extremely sound, and he stopped some shots with ease and judgment often not met with in "keepers" of far wider reputation. Fitz-Hugh was the best forward on the side, though both the left-wingers played well and hard, but we fancy that recent hard fights had a good deal to do with their bad shooting. Teams—

Guy's.—N. Lavers (goal); F. J. Lidderdale and A. B. Carter (backs); A. M. Daniel, N. C. Cooper and A. E. Crosby (half-backs); H. Hewetson (capt.), C. E. Hibbard, R. T. Fitz-Hugh, R. B. Stamford and L. Humphry (forwards).

Middlesex.—H. J. Clutterbuck (goal); R. H. Mornemont (capt.) and M. K. Tabay (backs); G. J. K. Mostyn, E. J. Dobbin and S. G. Worslay (half-backs); W. E. Huddlestone, A. C. Strand, E. E. Ellery, H. G. Ellery and A. R. Greenwood (forwards).

SURREY COUNTY ASSOCIATION FOOTBALL CUP.

Final Tie.

GUY'S v. REIGATE PRIORY.

The Surrey County Football Association chose Guildford as the scene of this encounter, on Saturday the 17th; and we cannot help thinking they might have done better, as the hill and position of the ground with regard to the sun both render scientific and accurate play a thing of some difficulty.

Reigate Priory were the first on the ground, soon followed by our men in detachments; and after the two elevens, standing in a crowd together, had been photographed, the men lined up as follows:—

Reigate Priory.—R. S. Ibbs (goal); C. E. S. Hardman (captain), E. W. Timmis (backs); H. Dungate, G. D. Morrison, H. R. Yglesias (half-backs); G. Brann, F. Nightingale, W. R. Alloway, F. H. Tyson, A. English (forwards).

Guy's Hospital.—L. Humphry, R. B. Stamford, R. T. Fitz-Hugh, E. C. Davies, F. E. Walker (forwards); A. E. Crosby, A. M. Daniel, H. Hewetson (capt.) (half-backs); H. B. Carter, F. J. Lidderdale (backs); N. Lavers (goal).

Referee: Mr. B. A. Glanvitt.

The loss of Cooper seemed a terrible blow to our chances, and the general opinion on the ground was that Reigate would be victorious; but it was not entirely an unmixed evil, as it gave Humphry another opportunity of showing his powers, or want of them, and he decidedly succeeded in the former process, as he played perhaps the first game of our division.

The Game.—Hardman having won the toss, and electing to play down hill, with the sun in his eyes for the first half, Fitz-Hugh kicked off soon after the advertised hour—3.30—amidst a burst of cheering, which showed that the Guy's team—rightly too—is not the most unpopular team in Surrey; for some of our Walton friends again turned up to wish us luck. Brann soon got away, only to be brought up by Lidderdale, after which a fine piece of play by Walker and Stamford

ended in Hardman conceding a corner, which, although a bully took place dangerously near their goal, produced no result. Even play followed for a time, until Carter, missing his kick, let in Alloway, who shot over. For nearly five minutes after this the game consisted of runs by Brann, who was played up to by the whole team, with disastrous results, and grand saving by Carter and Daniel alternating with shots over the bar by the Sussex amateur; presently Stamford got away well on the left, and from the resulting corner the ball was sent out. Ibbs now, for the first time, handled the ball, and was for a few minutes kept fairly busy with shots by Humphry and Walker, until Dungate relieved, after which Lavers had to come out and manipulate two shots from their left wing, Lidderdale being also prominent in the defence. After more give-and-take play, hands past half-way gave Guy's a chance, and a splendid shot from the foot of Fitz-Hugh produced our only goal some 15 minutes after the start. When the applause had in some measure abated the ball was re-started, and Humphry was prominent, until Tyson made a good effort, and Lavers was called upon to save a rush from their left wing, which he did most ably. Play was then stopped for a few minutes, as Nightingale, coming into collision with Carter, had cut his lip rather badly. Reigate, bent on equalizing, pressed for some time, and Carter put in some most excellent work, until a mis-kick by him caused Lavers to save, soon after which a corner was forced off Hewetson with no result. Grand play by Daniel and hands to us relieved until Brann shot in, and Lavers saved rather luckily, though the ball came awkwardly down the hill. The next item of importance was a run by Walker, who failed for the third time to get in his "centre." Guy's, however, continued to press, Humphry being particularly brilliant, and troubling Ibbs not a little, forced a useless corner. A rush by the Priory left was well stopped by Hewetson, after which from a corner beautifully kicked by Crosby, Davies headed in well, and had hard luck in not scoring, the ball going over. Reigate, chiefly owing to off-side against Humphry, had rather the best of the exchanges until half-time, when the score stood—

Guy's ... ... 1 goal
Reigate Priory ... ... Nil.

Nightingale now in the centre, with Brann next him on the right, re-started the ball for Reigate, who put considerable dash into the game, and helped by hands against us, kept our backs busy until the ball was sent behind our goal. Fitz-Hugh broke away but was robbed by Morrison, soon after which loud appeals were made by the spectators for a foul by Brann against Crosby. Reigate had again shot wide, when a fruitless bully took place in front of our goal from which Humphry broke away, and soon after Hewetson won applause for his tackling of Nightingale. We now pressed for a bit, when our full-backs put in some very good work; the ball again went behind our lines. Walker was now unfortunate enough to sprain his ankle, but pluckily continued playing soon afterwards, while Davies was seen to be suffering from an injury to the same part. Daniel, working hard the whole time, excelled himself in checking Brann, but still Lavers was compelled to handle and throw out. The left wing, though both injured, rushed well into their territory and forced a corner off Timmis which proved useless. Lidderdale was soon after this called upon to pull up Brann, when from touch near their goal, we gained another corner, which, though grandly sent in by Crosby, proved abortive. English now came away on the left, but hands relieved us and Davies took the ball back into their territory; soon afterwards the same player shot wide, when the Reigate left wing rushed down and forced a corner off Daniels, this proving abortive. Fitz-Hugh and Humphry made great efforts to increase our score, and Hardman had to concede a corner which Ibbs was successful in fisting out. Stamford now showed up on the left, but notwithstanding these efforts the ball returned to our goal mouth only to be sent behind. Lavers then made a grand save, and next Carter was prominent, so the ball returned to their half and Fitz-Hugh appeared to miss a good chance. Lidderdale was called upon to check a rush by the Reigate left wing, but the ball was sent on to Lavers, who threw out and gave a corner. The next item of importance was a corner to Guy's, which Davies headed in, but Ibbs checked. Nightingale now got away well, only to be forced to pass by Daniel, and the ball went out to the left wing, when English ran down; Hewetson successfully stopped his shot, but through a misunderstanding between our captain and Lidderdale, English was given time to rush up and bang the ball into the net, to the joy of the Reigate contingent and surprise of the Guy's followers. Only three or four minutes more remained for play, during which both sides made strenuous efforts to notch the winning point. Guy's had rather the best of the exchanges, and Fitz-Hugh looked like scoring again from hands near their goal. The score, however, remained unaltered, and time having been called, or rather whistled, an extra half-hour was ordered, Guy's playing for the first 15 minutes up the hill. Our men appeared to be much more fatigued than our opponents, though no doubt their injuries were beginning to tell on the forwards.

Brann had two good chances of scoring, but failed, when Humphry ran down well, only to be checked by Hardman—a foul to us, which was fruitless, was followed by more fast play, during which Stamford missed a fine chance through not passing, and then Carter was called upon to save repeatedly from Brann and Nightingale, which he did effectually.

During the second half of the time, Guy's had somewhat the better of the exchanges, though once we had an anxious time when a bully took place in front of our goal. Stamford—who was now showing most dash of any of the forwards—relieved with a good run. Hewetson then brought up Nightingale neatly, but nevertheless, Lavers was called upon to save, and throwing out, Fitz-Hugh was enabled to run down and force a corner off Timmis, which proved fruitless. Fast but scrambling

play followed until close upon time, when a foul was given against Lidderdale, but Reigate could not get the ball past Lavers, who saved marvellously, and so the game—a really exciting and grand one—ended in a draw of one goal each.

In conclusion, we have only to express the thanks of the team and others for the kindness shown them by Dr. and Mrs. Sells, who, with very welcome hospitality, gave us a most sumptuous tea before our return to town. The team succeeded in not only edifying the Guildford public with a grand exhibition of football, but in amusing them in their walk from the ground to the house of our kind entertainers, for a more woebegotten set of "crocks" probably never before wended their way through the streets of the old town.

Remarks on the game from the *Surrey Advertiser*.—The game throughout was carried on at a rare pace, the ball travelling from end to end at lightning speed. In the first portion of the game the Medicals were decidedly the smarter team, but on changing over Reigate showed superiority, as also in the extra time. The Hospital forwards were a speedy lot, and combined to great effect. Daniel as centre "half" did far more than his share of work to exceeding advantage, whilst at "back" A. B. Carter gave an exhibition of defence which would be hard to beat. In goal Lavers was particularly smart, and proved a worthy rival to the great Reigate custodian, R. S. Ibbs by name, who was as usual here, there, and everywhere. Reigate on the whole lacked the combination for which they are deservedly famed, and far too much use was made of Brann, who like Tyson, was off for shooting. Frank Nightingale was hardly as brilliant as usual, and Alloway, who was troubled by a weak knee, proved a defective shot. English, however, was at his best, and individually was perhaps the pick of the forwards of either side. Dungate never flinched from the severe task he was called upon to perform, and rarely has he been in finer fettle, whilst both Hardman and Timmis staved off the attack in grand fashion.

GUY'S 2nd XV. v. BROCKLEY.

On Saturday, March 17th, the second fifteen brought their season to a fitting termination by a brilliant victory over Brockley's first *seven*teen (fifteen players, one referee, and one touch judge), thus finishing up with a run of seven victories. It is but fair to our opponents to say that our team included Jones and Wetherell, but as the whistle was almost invariably blown as soon as either of these players touched the ball, very little benefit resulted from their efforts. The game requires but little description, consisting almost entirely of scrums, in which Brockley generally got the best of matters, being rather the heavier pack. Our men, however, collared beautifully, Mottram, Goddard and Saward deserving special mention. Towards the end of the first half, Bruce, by a brilliant run *in* touch, managed to cross our line, ran round and grounded behind the goal. The kick was but a poor attempt, and Cleveland easily charged it down. Guy's did most of the pressing during the second half, but Longinotto's defence was brilliant in the extreme, and succeeded in baffling all attempts for some time. At length, however, Jones picked up and ran in near the posts, Moore easily converting. Nothing further being scored, Guy's were left winners by one goal to one try, or five points to three. A large and enthusiastic crowd witnessed the game, and both sides, more particularly Brockley, were cheered from the ropes. One partisan of Brockley was overheard to remark indignantly to a spectator who expressed a preference for Guy's chances of winning, "Well, Guy's (pronounced Goy's) oughter win. They're playin' their fust agin Brockley's second." Indeed!!! Team:—

Guy's.—B. Muriel (back); J. Moore, F. Wetherell, H. Walling (three-quarter backs); M. P. Jones, H. T. Hicks (half-backs); A. J. Cleveland, N. H. Pike, W. Dykes, G. N. Mottram, E. G. Goddard, A. H. M. Saward, H. A. Moffat, H. Simson.

GUY'S 2nd XV. v. SIDCUP.

Played on our ground on March 10th. A well-fought game, during which neither side could cross their opponent's line, was very luckily won by Guy's, by four points to nil. Sidcup made several desperate efforts to score, but were unsuccessful, and it appeared likely that neither side would score, until Hicks, with a grand kick, placed a goal from a mark by Walker, about half-way through the second half. This being the only score, Guy's were left winners as above stated. Teams:—

Guy's.—B. Muriel (back); H. Walling, E. H. van Someren, T. Morgan, J. Moore (three-quarter-backs); H. T. Hicks, E. Morgan (half-backs); G. N. Mottram, A. J. Cleveland, W. F. Lindsay, A. H. M. Saward, E. G. Goddard, H. A. Moffat, C. C. Stead, C. H. Fagge (forwards).

Sidcup.—N. F. Terry (back); H. C. Mason, H. D. Green, E. S. Jerdein, O. T. Cousins (three-quarter-backs); J. Nussy, R. N. Dalgleish (half-backs); E. Bristow (captain), T. R. Jones, T. M. Gibbons, H. W. Cousins. H. A. Terry, R. Fooks, E. B. Yaldwyer, L. B. Jupp (forwards).

Birth.

CADEL.—March 18th, at Clare House, Tiverton, the wife of Nevil P. Cadel, L.R.C.P., &c., of a son.

Marriage.

PYE-SMITH–FOULGER.—On March 7th, at Christ Church, Lancaster Gate, Philip Henry Pye-Smith, M.D., F.R.S., of Brook Street, to Emily Gertrude, youngest daughter of the late Arthur Foulger of Chigwell Row.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual subscription to the Gazette *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers, who may be desirous of having their numbers of the Gazette *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette,

APRIL 14, 1894.

A Fatal Case of Raynaud's Disease

In a Girl having Mitral and Tricuspid Stenosis, Pericarditis, Acute Cardiac Dilatation, Pneumonia, Embolism of the Brachial Artery, and Atrophy of the Muscles of Feet.

CLINICAL LECTURE BY W. HALE WHITE.

Gentlemen,—The case we take to-day is that of Sarah Ann Hodson, æt. 16, who came into Miriam ward on January 19th, 1894, for dry gangrene of the toes of both feet and of the right hand and forearm.

Her report says that the patient is an orphan, who has been much neglected. She has never had rheumatism. For the last three years she has had palpitation and shortness of breath, and has been treated for heart disease as an out-patient at King's College Hospital. She said that during this time her hands and feet have often got very cold and sometimes blue She has had great difficulty in getting them warm again, even before a fire. Occasionally in the summer she has suffered from this. There is no account of her ever having been lame.

History of present disease.—On January 13th she felt pain in her feet and legs, and noticed that the toes of both feet were turning blue. On the 15th the tips of the fingers of the right hand became blue. They gradually got darker, and the discolouration spread upwards till it reached the point at which it stood on admission. The date of onset of the present febrile illness is doubtful.

Condition on admission.—She is extremely dirty, and badly cared for. Pulse, 116; respirations, 40; temperature, 101·2.

Her right hand and forearm up to within three and a half inches of the olecranon are gangrenous. The fingers are quite dried up, cold, of a dark mahogany colour, and horny looking. The veins show up against this dark background. The forearm is not so dry, and is of a blue-black colour. The upper limit of the gangrene is marked by a red line. No pulsation can be felt in the right brachial artery, but the third part of the axillary can be felt beating.

All the toes are gangrenous. On the right foot the gangrene extends about an inch beyond the base of the clefts between the toes. On the left foot it extends no further than the clefts. The tips of all the four inner toes on the right foot are dry, as are the tips of the three inner toes on the left. The dorsalis pedis and posterior tibial arteries on both sides pulsate well. The colour of the gangrene of the toes is the same as that of the arm. Its upper limit is, however, less sharply defined, and on the dorsum of the right foot there are two bullæ in the gangrenous area. There is nothing abnormal about the right hand. No scars are to be seen on the tips of any of the fingers or toes.

Heart.—Impulse diffuse. Apex in the seventh space, just outside the nipple line. Presystolic and systolic thrills can be felt over the apex. A presystolic murmur and a high pitched systolic murmur are audible here; the latter is conducted round into the axilla, and is very loud at the back. The second sound is accentuated. A slight pericardial rub can be heard.

Lungs.—Right side healthy. On the left side there is a pleuritic rub in the axilla. At the base of the left lung behind, and extending up to angle of scapula, dulness, consonanting râles, and loud bronchial breathing are present. The sputum is rusty.

Urine.—Healthy.

Spleen.—Neither enlarged nor tender.

Eyes.—Optic discs and retinal arteries normal.

She is menstruating.

The diagnosis made was that the patient had chronic mitral obstruction and regurgitation. That she had acute pneumonia and pleurisy on the left side, with pericarditis, and that this acute illness in a girl predisposed to Raynaud's disease had caused the gangrenous form of it to develope in the toes. The gangrene of the arm was regarded as embolic, secondary to the condition of the heart. Whether or not there was malignant endocarditis was left an open question. Six hours after admission the apex of the heart had gone two inches further out, it was thought that the pneumonia and pericarditis were inducing acute cardiac dilatation.

Turning again to the report, we find she is ordered Tincture of Digitalis, ♏x; Tincture of Nux Vomica, ♏x; Chloroform Water, ʒj, every four hours. The gangrenous parts are to be wrapped up in cotton wool. She is to be kept warm with hot-water bottles, and to be fed on milk and eggs.

January 20th. The temperature has remained about 103; respirations about 40; pulse 160. The physical signs are the same, except that the apex of the heart has moved still further out. The medicine is henceforth to be taken every two hours. She is to have two ounces of brandy a day, and a subcutaneous injection of ¼ gr. of Morphine every evening, because of the pain in the

gangrenous parts, and because of cardiac distress and sleeplessness.

21st. The temperature, pulse, respiration, and physical signs are much the same. The gangrene of the arm and toes is unaltered. On the left gluteal fold is a dusky red patch three inches in diameter, bluish in the centre, and yellow at the circumference like a bruise. This spreads across the middle line of the sacrum to the right side, where there is a similar patch. The symmetry of this makes us think it part of Raynaud's disease. The apex of the heart is beating just posterior to the mid-axillary line, and the diastolic murmur cannot be heard. As she has troublesome diarrhœa, Compound Catechu Powder is ordered, and as everything else fails to quiet her and to relieve her pain, she is given ¼ gr. of Morphine subcutaneously regularly night and morning.

24th. Since the last note the patient has improved. Temperature to-day 99·8. The blue-black colour of the back part of the gangrenous forearm is lighter, and so also are the fourth and fifth toes of the left foot and the patch on the gluteal region. The pulsation in the various arteries is the same as on admission. The apex of the heart is returning to its normal position, being now only one inch outside the nipple line. The pericardial rub has disappeared. The impulse is less diffuse. The diastolic murmur has returned, and is now mid-diastolic; the systolic murmur is unaltered. The signs of pneumonia are clearing up.

27th. The patient is better, her temperature is normal, the heart's apex is in the normal position, the murmurs are the same as on January 24th. There is only a little bronchial breathing at the base of left lung. The condition of the gangrene is unchanged. The patient's chief complaint is of great cardiac distress.

31st. Since the last note the temperature has been rising, and yesterday was 102·6. As the previous improvement renders it unlikely that the endocarditis is malignant, as the pneumonia has cleared up, and as the upper part of the gangrenous area of the forearm is becoming moist, the arm was to-day amputated through its middle, for it was thought possible that the patient's temperature was due to septic absorption.

February 3rd. The operation did not make the patient better or worse, the wound always looked healthy. The cardiac distress increased, and she died to-day.

Now, Gentlemen, when she came in, two criticisms were urged against the original diagnosis. It was in the first place suggested that the patient had malignant endocarditis, with consequently a considerable tendency to embolism, and that therefore the gangrene of the right arm and both feet was all embolic. But the reasons against this were very strong. In the first place, as the posterior tibial and dorsalis pedis arteries on both sides were beating well and forcibly, to produce gangrene of the toes there must have been an embolus in the dorsalis pedis just before it gives off its communicating branch, and in the external plantar artery in each foot; for, owing to the free communication between these arteries by means of the communicating artery, embolism of one alone will not cause gangrene of the toes. Just think of the chances against such a distribution as a pair of emboli in both feet. Also it is very doubtful whether such emboli would explain the extension of the gangrene on the right foot upwards beyond the toes. The commonest seat for an embolus is the spleen, but there was no evidence of this during life, and the one found at the autopsy was small and unimportant. Then, too, the retinal arteries are a frequent seat of emboli, but they were free in this case; in fact, there was no reason to suspect embolism of any internal structures. It seemed, therefore, that not only did embolism fail to explain the gangrene of the toes, but that there was no wide showering of emboli about the body, such as would have been expected if there were four emboli in the feet, although, from the lack of pulsation in the right brachial artery, we believed that an embolus was plugging it at its upper end. The subsequent history supported the view here urged for the fall of temperature, and contraction up of the dilated heart rendered malignant endocarditis, which alone would have explained an extensive showering of emboli, unlikely; and, therefore, we concluded that what had happened was that some non-infective ante-mortem clot accidentally detached, either from a vegetation, or from its seat of formation in some recess on the left side of the heart, had become lodged in the right brachial artery, and had thus caused the gangrene of the hand and forearm, but that the gangrene of the toes was not due to embolism.

Other critics suggested that the case was one of acute arteritis. The unfortunate part of this suggestion is that it is extremely doubtful if such a disease exists. Wilks and Moxon say they know nothing of it. They say, indeed, that cases of chronic arteritis are described, but with our patient the onset was certainly acute. Dr. Hadden has recorded one case of arteritis, Mr. Pearce Gould has recorded two—and gives references to others, but Mr. Gould is careful to point out that it is characteristic of the disease that there is "slow mummification of the part." I think, therefore, we may safely say that the patient had not arteritis.

Now, let us turn to the account of the post-mortem.

Post-mortem Examination.—Here are the organs before you, and most of the points I can now illustrate. On the left side of the chest there were twenty-two ounces of semi-purulent fluid, with flaky lymph in it. The lung is tough. On the right side there were two ounces of fluid, and there is much recent bronchopneumonia. The pulmonary artery is slightly atheromatous.

There are a few adhesions about the pericardium of such an age that they would correspond to the patient's pericarditis. There are some older adhesions on the front. The cardiac muscle is in many places very fatty and degenerate. The mitral orifice measures only two and a half inches in circumference. The valve is much thickened, and it is a typical button-hole mitral with

shortened chordæ tendinæ. The aortic valves are competent, but are fringed with a few very minute vegetations. The cavity of the left ventricle is normal, but the left auricle is much dilated and hypertrophied, and its endocardium is very thick. The tricuspid orifice is rather constricted, measuring only three and a quarter inches in circumference, and the valve is somewhat thick. The heart weighs fourteen ounces.

Kidneys.—There is some early tubal change. They are congested, and weigh nine ounces.

Spleen.—There is one small infarct of some date. Weight five ounces.

Liver.—Normal. Weight forty-five ounces.

After the amputation the arm was dissected, and the muscles are seen to be healthy; those in the stump are also healthy. Here, as you can see, a non-septic embolus is firmly fixed in the commencement of the right brachial artery, and a thrombus extends downwards for about an inch and a half from the embolus. The rest of the artery and the axillary are empty. The arterial walls are healthy. The muscles of the left hand are healthy. The posterior tibial and dorsalis pedis arteries in both feet are healthy and contain no emboli. The muscles of the legs are healthy. The muscles of the soles of both the feet, with the exception of the accessorius on one side and a few of the interossei on the other, are pale and in a state of degeneration.

Microscopical examination of the plantar and posterior tibial nerves shows that there is no well-marked neuritis, the greater number of the nerve fibres are quite healthy, and there are none which could be called certainly diseased, but here and there is slight evidence of inflammation, as shown by an excessive exudation of leucocytes. We may undoubtedly say there is no primary peripheral neuritis, and I think the proximity of the gangrene will explain all that we have found. Microscopical examination of the degenerate muscles of the soles of the feet shows that the greater number of the muscle fibres are replaced by fibrous tissue, but that the few that remain are for the most part healthy. There is much fat between the bundles of fibres.

I think the autopsy proves that the original diagnosis was correct. You can see for yourselves that there is mitral constriction, that with that valve there must have been mitral regurgitation, you will notice the dilatation and hypertrophy of the left auricle induced by the mitral constriction and regurgitation. The extremely bad condition of the cardiac muscle explains the ease with which, when the pneumonia and pericarditis supervened, the heart dilated. In one other case of severe illness occurring in an alcoholic subject suffering from heart disease, I remember seeing the heart dilate as rapidly as in this patient. You will notice here that in a few days we actually watched the apex of the heart move out some two or three inches, and return again taree or four inches to its normal position. The heart may dilate acutely in any fever, especially rheumatic and scarlet fevers, even if there has been no previous cardiac disease. The remains of the pericarditis we discovered during life were found at the post-mortem, and no doubt the pericarditis aided the dilatation. There was no malignant endocarditis. You will notice the tricuspid valve was a little constricted, and this will remind you that this association of tricuspid with mitral stenosis is fairly often found; why it should occur is not known, it certainly is not due to congenital disease as are most of the diseases on the right side. Tricuspid stenosis is much more frequent in women than in men; it is usually a chronic condition, and commonly much less advanced than the corresponding mitral constriction. This case illustrates all these points.

In the lungs you will notice that the pneumonia on the left side has cleared up, but that there is much pleurisy which might well correspond to the pleurisy which existed on admission. The broncho-pneumonia on the right side occurred shortly before death, as probably also did the left-sided pleuritic effusion, because two days before she died the left base was fairly resonant.

The embolus was found, as we thought, blocking the upper part of the brachial artery. You will notice that it is non-septic, and is producing no inflammation of the arterial wall, and has therefore not been derived from malignant endocarditis, but is due to an accidental detachment of some ante-mortem clot from the heart. The embolus in the spleen doubtless had the same origin as that in the brachial. As we prophesied, the arteries of the feet are healthy.

A little early tubal change, such as is present in the kidneys, may be seen in persons who have suffered from acute pneumonia, and very likely this patient's high temperature had something to do with it.

Both to the naked eye and to microscopical examination the muscles of the soles of the feet were in exactly the condition that would be left after an attack of anterior poliomyelitis; and as the nerves were almost healthy, it seems to me most probable that at some former period our patient had had an attack of this disease, affecting such of the cells of her anterior cornua as are connected with the plantar muscles. Atrophy of these muscles would not, when boots or shoes are worn, cause any easily noticeable difficulty in walking. *(To be continued.)*

The Gull Studentship.

The Gull Studentship in Pathology and allied subjects will become vacant on the 24th day of June next. The Studentship, open to candidates under thirty years of age who have studied in the Medical School of Guy's Hospital, is of the annual value of about £150, and is tenable for three years. Further particulars may be obtained from the Secretary of the Board of Electors, to whom applications must be addressed at the office of the Medical School not later than June 2nd.

Hospital News.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman.

1. A case of fistula in ano. Sinuses laid open. Patient now convalescent.

3. Old ununited fracture of femur. Treated by Mr. Bryant's double splint, and biniodide of mercury internally. A peculiar feature of this case is that the knee of the unaffected side became greatly distended with fluid while patient remained in bed, without any obvious exciting cause. Hydrops articuli.

4. Hip-joint disease.

5. Hernia, inguinal. Radical cure. Patient nearly well.

8. This is a very interesting case. Patient came in with a hard lobulated mass occupying the venter of the right ilium. The superficial glands in the groin were enlarged and breaking down. No history or evidence of specific trouble. First thought to be sarcoma; gumma discussed. Now supposed to be some inflammatory granulomatous swelling. Has diminished under biniodide of mercury. Mr. Howse pointed out that other swellings besides those of specific origin are very often absorbed by the biniodide of mercury. Patient improving.

11. Tubercular disease of wrist-joint. Treatment by partial excision, the lower ends of radius and ulna and first row of carpal bones being removed. Wound looks well, and patient progressing favourably.

12. Specific testis. Right testis was enlarged, hard and painless, and several punched-out ulcers in skin of scrotum. Treatment: Castration of right testicle; liq. hydrarg. perchlor. and pot. iod. internally. Patient going on favourably,

13. Excision of tongue, with removal of central portion of body of jaw, for epithelioma, involving tongue, floor of mouth and jaw. Syme's operation performed.

15. Impermeable stricture, with a false passage. Attempt to pass even the smallest instrument having failed, external urethrotomy (Syme's) was performed by Mr. Howse on the 11th inst., and a large-sized catheter tied in.

16. Necrosis of femur. Operation. Wound granulating up.

18. Recurrent epitheliomatous glands, submaxillary. Primary disease, epithelioma of lip. Excised some time ago.

Charity.

6. Girl, æt. 15. Very severe burn, especially with regard to area of skin involved. Hardly any skin below umbilicus and above knees, either front or back. If extent of area goes for anything, as the text-books teach, then the case is remarkable, inasmuch as the patient is alive. Skin-grafting by Thiersch's method has been done.

7. Dislocation of patella outwards, in consequence of rupture of internal alar ligament and tendency to genu valgum. Treated by Croft splint.

8. Radical cure of femoral hernia.

9. Compound fracture of surgical neck of humerus.

10. Depressed fracture of skull? Hæmatoma? Case sent up to College.

11. Fistula in ano.

12. Old colotomy, lumbar. Done six years ago for syphilitic stricture of rectum, and now escape of fæces "per anum" in consequence of insufficient spur made at time of operation. Treatment not yet decided upon.

13. This is an interesting case. First treated for intestinal obstruction. A large oval swelling could be felt in left loin; moves slightly with respiration. At first it was resonant behind, but at present time there is complete dulness behind. It is now considered to be kidney. Patient's urine contained a large quantity of albumin at first, but now is quite free from it. Bowels more or less regular by help of aperients.

18. Patient, æt. 84. Intracapsular fracture of neck of femur. Treatment, Hodgen's splint.

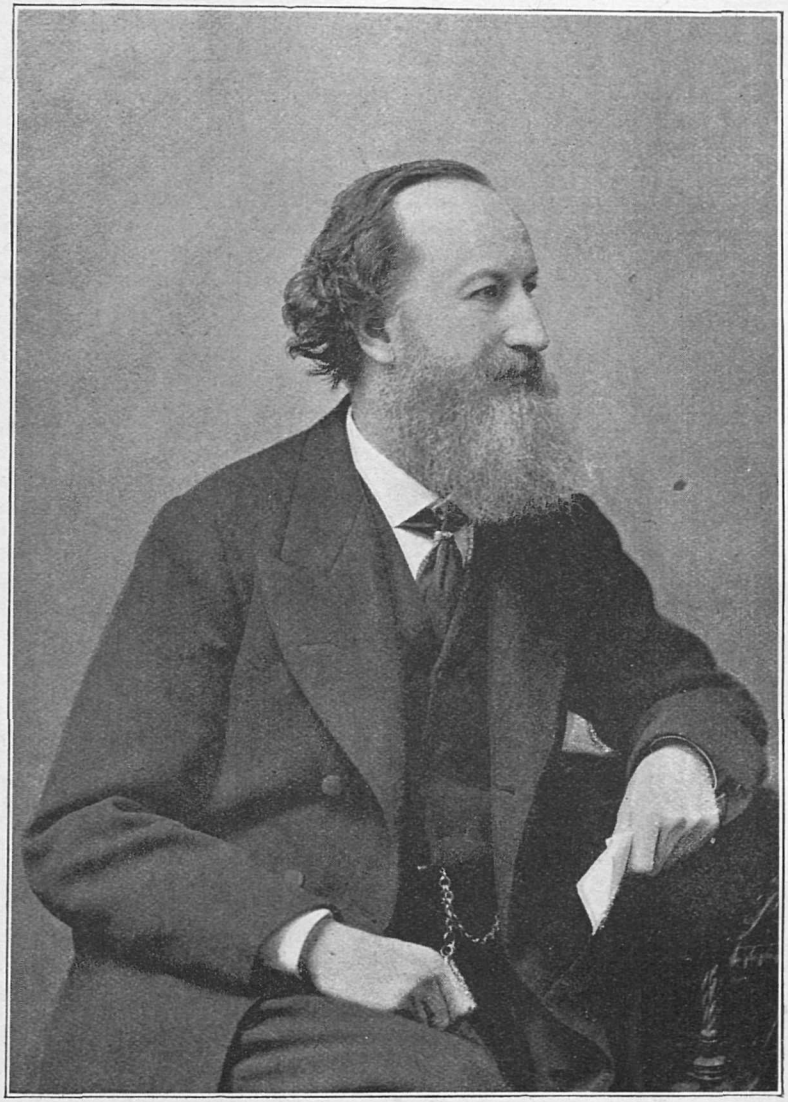
Cot D. Noma, following measles. Situation peculiar, in hollow between root of nose and inner canthus of right eye. A foul-smelling excavated sore with bone at bottom. Several subcutaneous abscesses on scalp. Sore scraped with sharp spoon and pulvis iodoformi applied.

20. Patient is a little girl æt. 4. Admitted for swelling on left side of abdomen. Sarcoma of left ovary. Abdominal section. Ovariotomy. A swelling about the size of a Tangerine orange can be felt in region of left sigmoid. The question of recurrence has been discussed. ? Fæces.

Accident.

7. Boy, æt. 15. Compound comminuted fracture of femur extending into knee-joint An endeavour was made to save the limb in this case. Limb was first of all put on a McIntyre splint and afterwards a double Bryant was used. However, the limb did not do at all well, the tissue being much devitalized from the severe injury. Hæmorrhage occurred on several occasions, the last one being alarming in character. Mr. Howse decided to amputate through the thigh. This was done, and the boy is now going on well, and looks much better. Health excellent.

32. G. B., æt. 52. Fractured pelvis. This case is of interest inasmuch as it illustrates the fact that pneumonia frequently occurs after external violence. "Contusion pneumonia of Litten." This patient, after being in hospital about ten days, developed a typical right basal pneumonia with high temperature, bronchial breathing, bronchophony, rusty sputum, and hard dry cough; pain; pungent hot skin. Tongue coated with white fur. Treated with il. Doveri and mixture of salicylates. Poultices to right base. Temperature now normal, and patient is now convalescent.



William E. Dunham

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The pneumonia is probably to be explained in these sort of cases by the fact that there is a lowering of the vitality of the body from shock or actual injury, thus producing a soil more favourable to the growth of the pneumococcus, and also a greater predisposition to the entrance of the micro-organism.—*Vide* Dr. Paterson's article on Pneumonia after External Violence, *Lancet*, January 20th, 1894.

Cases under Mr. Davies-Colley.

Lydia.

1. Nævus of arm.
3. Psoas abscess. Angular curvature.
4. Syphilitic necrosis of tibia.
5. Carcinoma mammæ, removed with contents of axilla, April 3rd.
6. Fibro-sarcoma of laminæ of fifth and sixth dorsal vertebræ. This patient was operated on in July, 1891, for a tumour at this spot. She had then complete paraplegia with girdle pain, ankle-clonus, and increased patellar reflex. After that operation she went out walking well, and was free from symptoms till three months ago. She was re-admitted on March 28th, with left-sided girdle pain, complete loss of power in the right leg, and severe paresis of left leg. Temperature sense was lost, as well as the sense of position in the legs; common sensation was defective. On March 30th the laminæ and spines of the fourth and fifth dorsal vertebræ were removed, and part of the sixth. Since then she has been gradually recovering power and sensation in her legs. Since the operation a clear watery fluid has been discharged through the wound, and has kept the dressings moist, so that the wound is healing less rapidly than it otherwise would have done.
7. Fracture dislocation of lower end of tibia and fibula.
8. Movable kidney, stitched March 20th.
9. Enlarged glands in groin, one of which suppurated. Cause not discovered.
17. Fistula in ano.
18. Rachitic curvature of tibiæ.
19. Hip disease.
20. Nephrolithotomy, March 20th. Patient now up and well.
21. Genu valgum. Horizontal osteotomy of both femora by Adams' saw through McEwen's incision; Croft's splints applied.
22. Abscess in head of tibia invading knee.
23. Popliteal abscess.

Luke.

1. Tubercular disease of upper part of humerus; abscesses. The elbow was excised some years ago for tubercular disease.
2. Disease of the great trochanter.
3. Pes cavus. The shape of the foot was restored by tenotomy of the tendo Achillis and extensors of toes and Hallux, the proximal end of the latter being stitched to the base of the metatarsal bone.
4. Excision of elbow on a jointed angular splint.
5. Radical cure of hernia. This patient had been operated on elsewhere for this hernia before, but the hernia recurred.
6. Hip disease.
7. Epithelioma penis. Amputation; removal of glands.
8. Urinary fistulæ.
9. Traumatic stricture of urethra.
10. Vesical calculus. A stone weighing 16 ounces was removed a month ago. Urine still comes through the wound sometimes.
11. Disease of great trochanter.
12. Hæmorrhoids. Phthisis.
13. Tubercular disease of testes, cord and versiculæ.
18. Osteomyelitis.
19. Ankylosis of hip.
20. Tuberculous synovitis of knee; eleven weeks' history; erosion April 10th. The patella was sawn through, the entire synovial membrane, the menisci and greater part of the crucial ligaments removed; the bones and cartilages were sound. The patella was joined with a double silkworm-gut stitch, the capsule stitched with cat-gut, and the skin united. A Croft's splint was put on over the dressing.
21. Excision of head of radius for old unreduced dislocation.

Cornelius.

2. Fractured tibia. Croft's splint.
3. Fractured femur, upper third. Hodgen's splint.
5. Fractured tibia and fibula.
6. Fractured ribs.
10. Scalp wound.
11. Compound fracture of ulna.
13. Synovitis of knee.
14. Scalp wound.
15. Fractured tibia and fibula.
18. Compound fracture of humerus.
19. Fractured tibia and fibula.

Cases under Mr. Lucas.

Accident.

Child, three years old, reported to have been run over by hansom cab. Much collapsed on admission. On examination, some bruising over chest, no ribs fractured. Respirations, 52. Pulse, 140. *Left chest* moves well. Breath and voice sounds exaggerated. Moist mucus râles in front and behind. Resonant. *Right chest* flattened at the side. Breath sounds much diminished, and gives the idea of air being blown through a cylinder into a cavity. Hyper-resonant. Child lies on right side always. *Diagnosis.*—Traumatic pneumo-thorax.

F. S., æt. 39. Admitted for pulsatile and slightly expansile tumour, the size of a walnut, situated in the submaxillary triangle. Patient has noticed it for ten years past; he cut it whilst trimming his beard. The tumour is the size of a walnut, movable, red and inflamed; pulsation much less lately. *Diagnosis.*—Cirsoid aneurysm. *Treatment.*—Dissected out wide of the aneurysm.

Job Ward.

T. G., æt. 49. Admitted for frequent micturition. Patient gives the following history. Two and a half years ago he found he had to pass his urine frequently, and at end of micturition he had a great deal of pain in penis. Has passed gravel frequently, never blood; no stone found on sounding. On admission, patient had a careworn, anxious expression, and was evidently very nervous about himself. He was treated with pot. bicarb. hyoscyamus and buchu; made some improvement but not much, so Mr. Lucas drained his bladder through the perinæum. At the end of three weeks the catheter was taken out and patient has gone home, being able to hold his urine for five hours at a time, whereas before the operation he could only last for forty minutes.

V. B. R., æt. 51. Admitted for radical cure of hernia. Patient is a heavy fat man, with a large inguino-scrotal tumour in left side. After making the usual incision and exposing the sac, which was empty, Mr. Lane found a protuberance outside the sac adherent to its lower wall. This, Mr. Lane suggested, was a diverticulum from the bladder; he confirmed his opinion by opening it and letting out a quantity of urine. He then sewed it up with fine silk, returned it, cut off the sac which was very fat, removed several subperitoneal lipomata, sewed the whole wound up, and tied a catheter in. Patient is making an excellent recovery.

Under Mr. Golding-Bird.

Lazarus.

4. Hip disease has been treated with long Liston splint and extension for four months. Is now to get up with a Thomas' splint and patten on other foot.

6. Enlarged glands in submaxillary region. Tubercular.

7. Carbuncle close to margin of anus. To be diagnosed from ischio rectal abscess.

8. Necrosis of radius, after injury. Three sinuses. Movable sequellæ.

9. Varicose veins, operated on.

10. Ectopia vesicæ, operated on many times, a bit at a time.

11. Perineal fistulæ stricture, large scrotal hernia.

12. Tubercular testes, double castration. Phthisis advanced.

13. Hæmorrhoids, operated on.

14. Varicose veins, operated on.

15. Extravasation of urine. Cock's operation, free slitting.

16. Long hard stricture. Cock's operation. Much thickening round urethra, yielded to mercurials.

17. Pulsating abdominal tumour. Question of diagnosis between growth and aneurysm. Leucocythæmia present with profound anæmia. Loud bruit varying in intensity.

18. Multiple tubercular lesions. Glands in neck, groin. Caries of metatarsal bones. Abscess in thigh.

19. Varicocele, operated on. Secondary traumatic orchitis.

22. Radical cure of hernia, operated on. Mr. Golding-Bird's modification of Barker's and MacEwen's operation, the whole sac being crumpled up and drawn up to the internal ring by a wire loop introduced through the skin from above. This case has already been once operated on in another hospital.

Martha.

1. Contracting scars after burn beneath skin, which produce deformity of mouth. Mr. Golding-Bird proposes plastic operation.

2. Small growth in right submaxillary gland removed, but section not yet examined. Not encapsuled.

3. Carcinoma of breast, amputated, glands involved.

4. Follicular abcess in axilla.

Cot D. Congenital talipes equinovarus. Tenotomy and wrenching; plaster of Paris.

7. Burn on buttock, very slow healing.

9. Chronic cystitis, probably tubercular, in child of three.

10. Syphilitic stricture of rectum. Typical history. Relapsing iritis. Treated first with bougies, and when no further dilatation could be obtained by division, three incisions one eighth of an inch deep were made; one posterior, the other two lateral. A full sized No. 9 bougie is now passed daily.

Cot B. Double hare-lip without cleft palate.

17. Spasmodic retention of urine; circumcision. Sounded for stone, none found.

18. Lupus scraped.

Cot A. Cleft palate. Hare-lip operated on.

19. Doubtful double hip disease. Question between say double hip disease and simple neurosis in a girl of six.

20. Old double amputation for injury. Boy, æt. 6. Left leg through knee-joint. Right through middle of leg. Walks about on two wooden legs, one a crutchet, the other for flexed knee.

21. Pes cavus operated on.

Cornelius.

1. Compound fracture of fibula and astragalus into ankle-joint. Removal of main portion of astragalus subsequently.

4. Ununited fracture of femur. Erysipelas of face soon after admission. Removal of piece of shaft of femur eight weeks after injury from cavity beneath the skin, but superficial to deep fascia.

9. Fracture into anterior fossa of skull. Star fracture of both patellæ. Collis fracture, right radius. Recovering.

16. Separation of lower epiphysis of humerus, with much bruising about elbow. Boy, æt. 4.

17. Compound fracture of tibia and fibula.

20. Ruptured ligamentum patella. Bronchitis pneumonia.

Accident.

2. Depressed fracture of skull, trephined spiculæ of inner table passing through dura mater removed. Doing well.

8. Psoas abscess after strain from lifting heavy weight, opened in loin. Doing well.

Cases under Mr. Jacobson.

Naaman.

20. Radical cure of hernia. Patient convalescent.

21. Epithelioma of tongue and floor of mouth. Operation March 30th, Syme's. After preliminary laryngotomy. Also removal of cancerous glands. Patient going on well.

22. Periosteal sarcoma of lower end of femur. Amputation through thigh, at junction of upper and middle thirds.

9. Epithelioma of tongue and floor of mouth, central portion of body of jaw also involved. Amputation through tongue, and central portion of jaw removed by two saw cuts about one inch apart; ends united by silver wire. Syme's operation performed. Soft parts of chin divided in middle line from edge of lip down as far as hyoid bone. No preliminary laryngotomy in this case. Patient has gone on remarkably well since operation. Pulse, temperature, and respiration normal. Fed for first day or so with nutrient enemata, and fluids by soft œsophageal tube.

Charity.

1. The patient, a middle aged woman, transferred from medical side, Dr. Taylor's ward. Spasmodic torticollis. Right sterno-mastoid very prominent.

Treatment — removal of portion of spinal accessory nerve. April 10th, Mr. Jacobson exposed the nerve by the incision along anterior border of sterno-mastoid, and removed about half an inch of the nerve just above its entrance into sterno-mastoid. Mr. Jacobson said that he preferred the anterior to the posterior incision for these reasons, (1) that the nerve exposed was then a single trunk and therefore not so likely to be confounded with other nerves, the third cervical for instance, which also emerges at the posterior border of the sterno-mastoid to supply the skin, the small occipital and great auricular also appear at the posterior border of the muscle, (2) that paralysis of sterno-mastoid was better insured, (3) when the nerve is exposed by the posterior incision and followed up into the muscle before division there is always a doubt as to whether some branch may not have come off above the place at which the surgeon has divided the nerve. Relief is not always permanent; generally speaking, in successful cases there may be immunity for eighteen months.

Reasons for operating.—1. Failure of palliative treatment. Conium, massage, galvanism. 2. Constancy and severity of spasms, interfering with the taking of food and sleep, and causing anxiety and suffering. 3. The sterno-mastoid and trapezius being the only muscles affected.

2. Carcinoma of right breast. Patient æt. 41. First noticed lump in right breast eighteen months ago, attributed to a blow. No history of cancer in family. Lump has gradually increased in size. Occasionally shooting pains in the breast have occurred, but on the whole the patient has been fairly free from pain. She has lost some flesh. On admission, skin over breast much puckered up, and the breast is smaller than that on opposite side. Skin was adherent all over to the subjacent mass. Nipple retracted, an indurated mass could be felt, the outline, size, and consistence of which were somewhat obscured by the puckering in the skin, subcutaneous, and breast tissue over it. Tumour not movable and adherent to pectoral muscles beneath. Glands in axilla enlarged. Above the breast two small nodules about the size of peas, also one on inner side could be felt. Mr. Jacobson pointed out that they were of bad prognosis. That the case was one in which an operation should not be urged on account of its long duration and unusual involvement of skin. On the other hand, patient was young and strong, and no evidence of visceral deposits, no cough or jaundice, and supra-clavicular glands were not enlarged.

Operation on the 8th. Whole breast widely removed. Axilla cleared out. Breast infiltrated with an extremely dense gritty growth, which on section showed no part of breast tissue uninvolved. Whole mass pyramidal in shape, with apex at nipple and base, situated on and involving the pectorals; the latter were freely removed, no secondary deposits in them.

Since operation patient has been going on well. Temperature normal, and the skin grafts which were put on at time of operation have taken well.

3. A case of bronchocele. Family history good. Neck first noticed to be enlarged when thirteen years old, gradually increased till twenty-five years of age; then swelling became hard, where before it had been soft. Has lately caused trouble by a feeling of pressure in throat.

On admission. A large irregular swelling could be seen in the neck overlapping sternum below and extending outwards under the sterno-mastoid on each side, and reaching nearly up to hyoid bone. The swelling was lobulated and lumpy looking. It followed to a certain extent the normal arrangement of the thyroid body, a prominence in centre and a distinct lobe on each side. The sterno-mastoids were displaced backwards and thinned out; one large pulsating vessel could be felt. Tumour firm and elastic, with prominence in places in which fluctuation could be obtained. No difficulty in swallowing.

Treatment. Excision, a portion of right lobe only being left. Patient has not had a bad symptom since. Pulse, temperature and respiration normal. Wound healthy. Takes food well. Voice somewhat husky. No dyspnœa or spasm. Tumour removed was lobulated, and on section showed cysts which contained a blood-stained fluid, the cysts being held together by a capsule of fibrous tissue; two lobules were solid and smooth on section, and mottled red in colour.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Philip. *Cardiac Cases.*

21. Ague, aortic disease, ascites.

27. Innominate and aortic aneurysm, hemiplegia.

36. Mitral and aortic disease, hæmaturia, pyrexia. (? fungating endocarditis).

39 and Mary 27.—Rheumatic fever, endo-, myo-, and peri-carditis, mitral incompetence, adherent pericardium, auricular and ventricular dilatation (two almost exactly parallel cases in children).

Dr. Pitt contrasted the case in *Mary 27* with that of a boy in *Philip 39*. The murmurs due to actual valvular incompetence are not always distinguished, as they should be, from those due simply to the swelling of the valves, which is associated with endocarditis. The latter will tend to vary in character from day to day, and may, of course, ultimately disappear. It has been shown that true incompetence cannot be established within four weeks of the onset of endocarditis. In *Philip 39*, for instance, there is no incompetence. In *Mary 27* there was, at one time, an aortic murmur due to endocarditis, which has cleared up; while there is well-marked incompetence of the mitral valve.

Philip. *Pulmonary Cases.*

34. Pleuritic effusion, (?) phthisis.

40. Dry pleurisy, phthisis, localized pneumothorax.

Mary.

26. Acute phthisis.

28. Pneumonia.

31. Pleuritic effusion.

32. Phthisis, severe hæmoptysis.

Philip. *Renal Cases.*

23. Acute nephritis.

30. Renal calculus.

31. Chronic interstitial nephritis, emphysema and bronchitis.

Mary.

34. Tuberculosis of right kidney, ureter and bladder.

Philip. *Enteric Cases.*

29. Enterica.

37. Enterica. Three separate relapses. Duration fourteen weeks.

Mary.

37. Enterica.

Cot 55. Pyrexia and constipation (? enterica.)

Philip. *Nervous Cases.*

25. Cerebral tumour, optic atrophy.

Mary.

25. Alcoholic neuritis affecting all four limbs.

35. Anorexia nervosa.

30. Neuritis following scarlatina in a child of four. Choreic movements, absent knee-jerks, and ataxia were the most prominent symptoms, all of which have greatly improved. She has been taking arsenic. Dr. Pitt thought of Friedreich's ataxy at first, but the great improvement which has taken place makes it almost certain that the trouble was due to some temporary condition only.

29. Probably disseminated sclerosis following diphtheria. Ten years ago patient had an attack of paralysis of the legs, with œdema of the ankles, which went off in the course of three months, so that it was probably functional. A year ago she had diphtheria, and as soon as her throat got well her arm and leg became weak. The symptoms are nystagmus, slow speech, paresis of left arm and leg, tremors, inco-ordination, increased tendon phenomena and ankle clonus. Quite lately she developed an acute basal pneumonia, very insidiously, and then it was found that the action of the diaphragm was exceedingly imperfect.

Cases under Dr. Taylor.

Stephen.

3. Crossed hemiplegia with mental defects. Improvement under pot. iod. ʒij. t.d.s.

4. Mitral disease: ascites; pulsating liver.

6. Carcinoma of œsophagus and cardiac orifice of stomach.

7. Locomotor ataxy. Gastric and bladder crises.

8. Empyema. Operation. Favourable progress for six weeks, then pain about heart and shoulders set in. No cough. Temperature 102. Respiration 44. Pulse 154. Curious heart sounds, suggesting pericarditis. Orthopnœa. ? Pericarditis. ? Pulmonary thrombosis. ? Relapse of deep-seated pneumonia.

9. Adenoma sebaceum in an epileptic child. Note nævoid growths on face, and thickened fibroid nodules about face and body; also peculiar patches of rough skin about trunk, c.f. wax model in Museum, 262.

11. Diabetes, taking 32 grs. of opium daily. Sugar gone. Weight increased by 30 lbs.

13. Diphtheritic paralysis.

15. Pleurisy (? tubercle).

18. Bedsores and asthenia, the after effects of acute rheumatism.

19. Peripheral neuritis following a septic finger.

20. Wasting of hand. ? Early idiopathic muscular paralysis.

Mary.

33. Chorea mitral regurgitation.

37. Phthisis.

40. Dyspepsia.

41. Nocturnal incontinence of urine.

42. Diffuse myelitis. Optic atrophy, bed-sores.

43. Convalescent typhoid.

46. Rheumatism. Mitral regurgitation.

48. Tubercular peritonitis.

49. Phthisis.

Cot 56. Empyema. Contraction of diseased side. Commencing lateral curvature.

Cases under Dr. Goodhart.

Philip.

2. J. E., æt. 39. Obscure sensations of heat and cold in feet at night, not reacting to treatment. ? Gouty. ? Neurotic. Has also phthisis; sometimes grass-green sputum.

5. J. G., æt. 20. Primary Bright. Secondary dilated right heart; uræmia; delusions; Cheyne-Stokes' breathing. Insomnia and restlessness improved by morphia. Increasing anasarca, necessitating puncture of legs.

Venous pulsation in neck; enormous liver; fluid in abdomen and chest.

3. T. W., æt. 14. Fibroid right lung, with extensive cavitation. Heart displaced to right. History of right pleurisy. Phthisical family history. ? Pleurogenous pneumonia. ? Tubercle grafted on bronchiectasis.

14. T. H., æt. 9. Pseudohypertrophic paralysis with mental deficiency; large firm calves; weakness of legs; unable to walk alone. Wasting of lower part of pectorals; also of muscles of arm on both sides. Been getting steadily worse for several years.

MARY.

13. C. A., æt. 26. Renal tumour. Pus in urine two years. Operation. Four calculi removed, and pus evacuated. Doing well.

17. B. L., æt. 11. Aortic and mitral bruits. Universal enlargement of glands. Albumin, blood and casts in urine.

18. M. G., æt. 27. Attacks of abdominal pain at intervals for two years. Fæces pale after attack; no jaundice; liver slightly enlarged; doubtful tumour in position of gall bladder.

19. S. G., æt. 17. Rhythmic movements of right side and head; never left side. Occasional rise of temperature, with pains in limbs, not joints. Brother has chorea. Heart normal. Movements now cease, *e.g.* for fifteen minutes, then recur. ? Hysteria. ? Chorea.

UNDER DR. HALE WHITE.

MARY.

9. E. P., 40. From 1881 to the end of 1883 patient was in the surgical wards with pelvic suppuration and a sinus in the gluteal region which discharged about ℥ss of pus daily. The abscess opened into the bladder. Before her discharge from the Hospital the liver was palpable, and there was albuminuria (even when no pus or blood in the urine). Sinus closed up five months after leaving Hospital, and two or three years later patient first noticed her legs begin to swell. Since then the œdema has been greater or less according to the extent to which the patient has been on her legs. She has suffered from headaches, aching pains in the back, and tenderness over the œdematous tissues. For the last year she has noticed her face to be puffy.

She was admitted with aggravation of the above symptoms. Pulse, high tension; no recognisable heart changes; no ocular changes.

Urine.—Six parts per 1000 albumin acid. Sp. gr. 1020, urea 1·4 per cent.

Dr. Hale White discussed the probable condition of the kidney. The general condition of the patient, character of the urine, etc., pointed strongly to the present illness being tubal nephritis. As to the antecedents, there was ground for discussion. Three alternatives—

(1) The kidneys were originally lardaceous (due to suppuration in 1881-3). The presence of lardaceous material in the kidneys is always accompanied by tubal nephritis. This and the lardaceous deposit cleared up, but the kidneys would be left liable to subsequent tubal nephritis, which had now supervened. It is unlikely that the kidneys are lardaceous now, because—

  (i.) Lardaceous disease would in eleven years have either cleared up or killed the patient.

  (ii.) Liver and spleen are not now palpable. (Palpation difficult on account of obesity of patient).

(2) Tubal nephritis on granular kidney. Granular kidneys do often become the seat of tubal nephritis.

Against this—Cardiac changes not marked, and there would be no association between her granular kidneys and the previous lardaceous disease of these organs.

(3) A first subacute attack of tubal nephritis. Against this is the history: from the latter it seemed almost certain that lardaceous disease had at one time been present, so that the diagnosis arrived at was a second attack of chronic tubal nephritis in a case in which the primary tubal nephritis had been due to lardaceous disease of the kidneys.

6. M. A. S., 66. Abdominal tumour. The tumour has the following characters: it stretches from the left hypochondrium across the middle line just above the level of the umbilicus. Its vertical diameter appears from palpation to be about two inches on the right, and one and a half at the left extremity. It is situated at the back of the abdomen, is fixed, hard, and very tender.

Dr. Hale White on his first visit raised the question of its being impacted fæces.

In favour of this being its nature were—

(1) Condition of patient not bad enough for growth of that size.

(2) Patient has been constipated lately.

(3) Tenderness. This character favours scyballa more than growth; a larger percentage of the former are tender than of the latter.

Against—

(1) Fixity.

(2) Position (at back of abdomen).

(3) Consistence (hard).

An enema was given which acted, but had no effect on the tumour. "Impacted fæces," therefore, was excluded.

Possibilities.

(1) Omentum (puckered up by growth, chronic peritonitis, or tubercle).

(2) Growth in transverse colon.

(3) Growth in pancreas.

(4) Growth in greater curvature of stomach.

(5) Normal pancreas.

(6) Horse-shoe kidney.

(1) Puckered up omentum.

For.—Position in horizontal plane, comparative frequency of such a condition.

Against.—Fixity and position at back of the abdomen.

(2) Growth in transverse colon.
For.—Position in horizontal plane.
Against.—Extensive nature without definite signs of destruction, or peculiarity of motions. Fixity and position at back of abdomen.
(3) Growth of pancreas.
For.—Position and tenderness.
Against.—Its extension to the right. Patient's general condition.
(4) Growth in greater curvature.
For.—Position in horizontal plane; tenderness.
Against.—Absence of definite gastric symptoms; patient's general condition; position at back of the abdomen.
(5) Normal pancreas.
For.—Flaccidity of abdominal walls rendering palpitation of normal organs possible. [Case described, in which tumour noticed clinically turned out to be normal pancreas.] General condition of patient.
Against.—Tenderness and extension to the right.
(6) Horse shoe kidney.
For.—Position.
Against.—Shape, size and rarity.

In conclusion, Dr. Hale White said that as so much was to be said against such views, it was impossible to arrive at a definite diagnosis.

11. Aortic stenosis and regurgitation—practically no signs of mechanical heart failure.

It was pointed out that this case afforded a remarkable illustration of the way in which compensation takes place; for, notwithstanding the severe nature of the lesions, the girl had worked at a mangle for years, yet there were no obvious signs of heart failure (considered mechanically). Patient complains of cardiac pain—such symptoms as she complains of are much more difficult to relieve than those of mechanical heart failure.

Notes on Dr. Shaw's Demonstrations in Pathology.

Bright's Disease.—This may be described under the four following types of kidney, which are sometimes found as successive stages of the same disease.

(1) Large red (2035[80]). As seen by the naked eye, the kidney is very much enlarged. This increase is mainly in the cortical area. The capsule peels easily, and the stellate veins on the surface are engorged.

On section, blood flows freely from the cut vessels, hence called "blood-dripping" kidney. This nephritis may be divided into tubular and glomerular, according as the mischief is mainly in the tubules or the glomeruli.

The scarlatinal nephritis is thought to be glomerular.

(2) Large white (2037, 2037[50], 2038[50], 2039). This form is usually developed from the preceding, but may occur as a primary condition.

The kidney is larger than (1), the capsule strips easily, and the surface is smooth but mottled. Stellate veins are very conspicuous. On section, a streaky appearance is well-marked. There is an enormous contrast between the whiteness of the cortex and the redness of the pyramids.

The pallor is due to the tubules being more distended with degenerative products, and thus causing compression of the capillaries.

(3) Small white (2041[10]). This may arise from shrinking of the large white, or from tubal change in the small red.

(4) Small red (2041[2], 2040[15], 2043[50]). It rarely results from acute nephritis. More commonly it is a primary disease, and may be caused by gout or lead poisoning, and also arises in elderly people as a chronic senile change. The main feature is smallness. The capsule is thickened and very adherent, pulling off renal tissue with it. The surface is granular and shows cysts.

On section, the renal arteries appear much thickened and the cortex is wasted.

Lardaceous Disease (2036[5]).—Lardaceous disease without inflammation; kidney larger and firmer; peels well. On section, translucent paler than usual, because lardaceous material contains no blood-vessels. The Malpighian capsules are easily seen, and stain more deeply with iodine. Lardaceous disease predisposes to tubal and to interstitial nephritis, but more frequently the former.

Gummata (2032[50]).—Gummata in the kidney are rare, and in consequence, some pathologists decline to accept scars in the kidney as evidence of shrunken gummata.

Urate of Soda (2024[75]).—Probably deposited, post-mortem as the body cools.

Injury (2063, 2063[50]).—May cause a perinephritic abscess.

Cysts.

(1) *Retention* (2043[50], 2044, 2048[32]).—Occasionally single, generally multiple; result from chronic interstitial nephritis, owing to the unequal contraction of fibrous tissue, which causes blocking of the distal ends of the tubules.

(2) *Congenital* (2048).—Clinically patient has a double renal tumour, with ordinary symptoms of Bright's disease.

These cysts are often associated with multiple cysts in the liver. They are sometimes regarded as a form of malignant growth. It is said to originate from interstitial nephritis during fœtal life, and the kidneys at birth may be so large as to hinder parturition.

Hydatid (2027[13], 2047[80]).—Not uncommon. Often diagnosed as hydronephrosis. Daughter-cysts may pass into the pelvis of the kidney and cause renal colic. Old cases may resemble the "mortar" kidney of tuberculous disease, but the calcareous matter is confined to one end of the kidney.

Passim.

The absence of the Gazette in Easter week prevented due notice being given to old Guy's men of the fact that the dinner to Mr. Durham was, after all, open to all comers. We regret very much the large amount of disappointment which the absence of this information has caused. All who were present received a portrait, with autograph signature, of the guest of the evening. We are happy to be able to supply absentees with the next best thing—an excellent reproduction of the same. The portrait is by Jerrard, of Regent Street.

In the extreme and general regret at the death of so brilliant and greatly esteemed a man as the late Lord Bowen, we at Guy's have a personal interest, for he was one of the Governors of the Hospital. It will be within the recollection of many of our readers how Lord Bowen, about ten years ago, distributed the prizes on the occasion of one of the most successful of the old conversaziones. Those who then saw and heard him, still remember the graciousness and charm of manner which distinguished the deceased judge, and are the better able to appreciate the tribute of the Master of the Rolls: "His knowledge was so complete, that it is almost beyond my power of expression. His reasoning so extremely accurate and so beautifully fine, that his points sometimes escaped my mind which is not so finely edged . . . and the beautiful mind distinguished him in social life as much as his perfection of conversation. In that life he obtained the affection of everybody who happened to be on intimate terms with him."

The retirement of Sister Clinical will be the occasion of wide-spread regret. She has spent sixteen years at Guy's, and for fourteen years has been in charge of the clinical wards, where her rule has resulted in a standard of excellence never surpassed in any hospital ward in London. Those who have worked with her know well how keen has been her enthusiasm for all that makes for the welfare of the wards and of the clinicals. We wish her the highest happiness in the new life she has chosen.

Although a copy will already be in the hands of many of our readers, we have thought it well to reproduce in another column the Report of the Guy's Nurses' Institution for 1893. The Report is one of such exceptional interest, that its details should be widely known. The new departure in the matter of a Bonus Fund, which is invested for the benefit of the Nursing Staff, seems to us to be based on the soundest principles. The Treasurer and the Managers of the fund are to be congratulated on initiating a procedure which we hope will commend itself to the financial authorities of other similar institutions.

To judge from letters which we occasionally receive, some of our readers are enthusiasts in the matter of the betterment of the nursing wage. If we have not published these letters, it is because they generally drag in matters which are outside the functions of the Gazette. There is, however, one point on which these correspondents are agreed, and this we venture to refer to here. It is that no nurse ought to be subject to loss of salary during illness which can be attributed in any way to risks run in the pursuit of her profession. This we think should be recognised by the authorities of all Nursing Institutions.

There will be a practice wicket ready at our ground to-day for keen cricketers. The tennis courts will be ready as soon as we have had a little rain; or, in any case, one court

at least will be ready by the end of next week. This drought is, of course, terribly against the preparation of grounds for summer games.

The strong hopes that Guy's Association Team would bring home the Surrey Cup were quickly dispelled when the final tie was re-played at Guildford on the 31st ult. The game was not half-a-minute old before Reigate Priory, from a rush down the hill, had scored a goal. After allowing for the effect of such a disheartening start, however, it must be candidly admitted that our team never looked like winning from start to finish. Seemingly, utter want of condition on the part of the majority of our players rendered their efforts uncertain and ineffective. Carter and Lidderdale at back, and Daniell at half-back worked like Trojans, and, had the general slackness infected them also, we dread to speculate upon the humiliating character our defeat would have assumed. As it was, Guy's retired beaten by four goals to nil, much to the disappointment of the local crowd, who showed their partiality for the Hospital by silence varied by howls of execration at Brann, whose Sussex origin was resented in terms more forcible than polite. The general opinion on our play was that of a well-known old Guy's man, "No one would recognise this as the same team which played a draw here a fortnight ago; all their combination is gone."

The volumes for 1840-48, and volume ii. for 1866, of the *Lancet* are needed to complete the Library series. If any readers of the Gazette have any of these volumes they can dispense with, they would greatly oblige the Library Committee by sending them to the Hospital Librarian.

Appointment.

Ballard, Chas., M.R.C.S., has been re-appointed Medical Officer for the Fifth Sanitary District of the Abingdon Union.

The Dinner to Mr. Durham.

This was held at the St. James's Restaurant, on March 31st, at 7.30 p.m., and proved, as was to be expected, a very great success.

About one hundred Guy's men assembled to do honour to Mr. Durham. There were present the following members of the staff:—W. H. A. Jacobson, M.Ch. (in the chair), J. H. Bryant, M.D., John Fawcett, M.D., A. L. Galabin, M.D., C. H. Golding-Bird, F.R.C.S., J. F. Goodhart, M.D., W. A. Lane, M.S., G. B. Smith, F.R.C.S.

Amongst other old Guy's men present were:—S. R. Alexander, M.D., G. Black, M.B., W. F. R. Burgess, M.D., L. Burroughs, J. E. B. Burroughs, F. F. Burghard, M.S. H. Blatherwick, H. E. Cuff, M.D., F.R.C.S., H. E. Counsell, F.R.C.S., H. W. Drew, F.R.C.S., W. T. B. Donnelly, M.B., Frederick Durham, F.R.C.S., H. E. Durham, M.B., G. H. S. Daniell, M.B., D. Elcum, J. A. Fraser, E. A. Farr, A. Gillingham, E. W. Goodall, M.D., F. Heatherley, F.R.C.S., T. Halliwell, J. B. Howell, H. V. Hickman, M.B., W. J. Heddy, W. H. Jalland, F.R.C.S., J. H. Joyce, M.B., H. R. Ker, F.R.C.S., C. A. Lumley, E. E. B. Landon, E. Jackson-Lang, R. A. Milligan, F. J. Nisbet, R. J. Pye-Smith, F.R.C.S., J. Poland, F.R.C.S., G. Rowell, F.R.C.S., Lockhart Stephens, Lennard Stokes, C. E. Salter, M.D., F. G. Swayne, M.B., A. W. Sheen, M.D., F.R.C.S., Sidney Turner, F. Meadows Turner, M.B., A. R. Ticehurst, M.R.C.P., J. C. Uhthoff, M.D., F.R.C.S., Sidney Wacher, F.R.C.S., J. Young, M.B.

After the usual loyal preliminaries the chairman gave the toast of the evening—the health of Mr. Durham. In a brilliant and eloquent speech, he said:—

When, Gentlemen, I was asked to take the chair at this dinner by one of your committee, I gave, as I hoped, good advice. I pointed out that though it happened that, by the death of Mr. Poland, I became Mr. Durham's first full dresser in October, 1872, there were others, my seniors (Dr. Goodhart and Dr. Galabin), who had worked with him before, and who were better fitted than I am to occupy this place. This advice was, of course, rejected on the spot, most urbanely, I admit, but, like all the advice I give, put aside at once. The answer I got reminded me of a remark which Swift somewhere makes, that while men will always take money they will never take good advice; and from this Swift goes on to argue, in his own fashion, that money is better than good advice, an argument with which, from my experience at Guy's, I am fully inclined to agree. But when I found that there was no help for me, I looked about and took comfort where I could. If there was no reprieve, I should, at least, pay the penalty pleasantly, for I should sit next to, and take part in paying honour to one of the most lovable men I know. And I took further comfort that this is no ordinary meeting. Our dinner to-night does not come under the ridicule which often attaches to the English public dinner. You know what I mean. The habit of dining together on every conceivable pretext. Does the Stage, or as it prefers to be called, th

Drama, want support? The Englishman dines out on Monday. Does the Press require a sop? He dines out on Tuesday. On Wednesday the name of some lately lauded lion calls him out again. And strangest of all, are the stomachs of others most cruelly pinched, and in need of filling, the Englishman first fills his own! Nor is this habit limited to London. I am given to understand that in the Provinces, if it happens that during his year of office the wife of some Mayor happens to present him with an infant, the Corporation promptly calls upon him to dine with them, as if he had performed some highly meritorious and praiseworthy action. No! our meeting is no such common one. It is, I maintain, almost unique. For it must be extremely rare for men to meet together, and come from long distances and at great cost of time and trouble, the majority of whom, if asked to state their feelings towards the guest of the evening, would reply, "Well, it is a strong thing to say, but if there is a man whom I *love* it is Arthur Edward Durham." Standing here as your chairman to-night, as your mouthpiece, to propose the health of our very dear old friend now that he and we, alas, have come to the parting of the ways, I know no better way of honouring the toast of the evening than by giving the reason—though in lame and halting words—how in twenty-two years that feeling has arisen, and how it has gained strength. It is because Mr. Durham has habitually shown how a man can keep fresh and free from rust and tarnish those characteristics of a child which, as we pass mile-stone after mile-stone of life's way, we acknowledge to be amongst childhood's chiefest charms. I refer to his Simplicity, his Unselfishness, and Power of sympathy. Now, by his Simplicity, I mean absolute want of show; I mean simplicity of the heart, not that of the head—of that our old friend has none, he is eminently shrewd and knowing, more so than some of his dressers have thought,—No! I refer to that quality of the heart and of the life expressed by the words: "in simplicity a child." To explain my meaning, Coleridge says that every man should include all his former selves in his present life, just as a tree has its former growths, circle within circle, inside its last. Now, I maintain this is eminently true of our guest. He is a splendid instance of a very rare genus, men who, at all stages of their life, have been the same. We all know people who, after being of "the right sort" as boys or men, have deteriorated, "put on side," gone back in some way or other as they have grown older. I am certain that Mr. Durham has been the same in Simplicity, Unselfishness and Sympathy at all stages of his life, and the proof of this is shown in the instances which all of us know of in the recesses of our hearts that he has carried along with him, through times of sunshine and of cloud, up till to-day, his sixtieth birthday, traces of his childhood, his youth, his manhood, and mature middle age. It is this, Gentlemen, which has kept his heart so young and tender; it is this which has enabled him, above all men I have ever known, to sympathise with, and have such a fellow-feeling for all, whatever their rank and age and sex might be. Of his Unselfishness and Power of sympathy, time would fail me to speak duly, and I must be mindful of your patience, and the fact that this is the hour and this is the place for one man only and but one speech. I will only say that I have ever admired and envied what I will call the spaciousness of Mr. Durham's nature. Behind that ample forehead, in that capacious, hospitable heart, he has had abundant room for taking in and cherishing a very wide range of human thought, human affection, and human feeling. And why has it been natural for him to do this? Because, with him, as with all good and uncommon men, he has been several men in one. And now, before I formally give the toast of the evening, I have one more point, if you will bear with me, as a suggestion to mention. It is one which I think you will allow me, as your chairman, to make. I think I might go further, and take for granted that everyone who loves the name of Durham will expect me to make it; and that is that this dinner, pleasant as it has been in every way, and one for which we all owe thanks to our committee, will be but a poor affair, and but a fleeting and soon-forgotten sign of our regard for Mr. Durham, if we do not go further, and if some steps are not taken for founding in perpetuity some proof of our love for our guest of to-night. And now, gentlemen, *nunc est bibendum*—in a few moments we shall be drinking his health, but as he is no ordinary man to us, so let it be no ordinary toast-drinking. With this toast I will couple two wishes, one for him, the other for ourselves. That this evening, as it comes back to his memory, may cheer and sooth him, and that the recollection of all your faces round him may keep his heart young and tender into a very ripe old age. The other, a wish for ourselves, that we may prove ourselves apt pupils of our old teacher, by showing to others at every possible opportunity, some of that spirit of Charity, Humility (rare at all ages and especially so now), that Simplicity of character and Unwillingness to think evil of others; traits which we, his pupils, have seen, again and again, playing softly over every day of his life—traits which we shall ever associate, in their perfection, with the name of

ARTHUR EDWARD DURHAM.

Mr. Durham's reply will be long remembered by all who had the privilege of being present. He spoke with much emotion, and it could be felt that his retirement from active life at Guy's was a matter which moved him very deeply. The autobiography, which formed much of the subject matter of the speech, we hope before long to be able to place before our readers, and at the same time, if Mr. Durham will allow it, we shall endeavour to produce a historical series of his portraits, such as other members of our consulting staff have already given us.

A vote of thanks to the chairman was proposed by Dr. Goodhart.

Messrs. Coulson, Robinson, and van Someren contributed musical items to the evening's entertainment.

The occasion fittingly closed with the singing of Auld Lang Syne, and hearty rounds of cheers for Mr. Durham.

Guy's Hospital Trained Nurses' Institution.

REPORT FOR 1893.

In presenting to the notice of those interested in the Institution his Annual Report for 1893, the Treasurer has to observe that the past year has been signalised by events of unusual importance, and by developments which have, he believes, placed the Nurses engaged upon the Private Nursing Staff of Guy's in a position at least as advantageous as any to be found elsewhere.

In the early part of 1893, Miss Sarah A. Swift succeeded Miss Nott Bower as Lady Superintendent of the Institution, upon the appointment of the latter as Matron of the Hospital.

The number of Nurses employed during the past year has risen from 62 to 82, and even this large increase in the Staff of the Institution has been barely sufficient to satisfy the demand which exists for Nurses trained at Guy's and of known trustworthiness and capacity. For many months consecutively scarcely a Nurse, save those upon the sick list, was without employment, but such an exceptional state of things is hardly likely to continue, and it is becoming a serious question where to find room for the proportion of Nurses who may be expected during the coming summer months to require temporary accommodation for some weeks in the Institution or elsewhere. It is generally considered that the beds to be provided for such a contingency should not be less than twenty per cent. of the total number of Nurses engaged, and even if the present Staff be no further increased, the sleeping accommodation in the Institution falls short of this percentage.

The fees received for Nurses' Services, etc., have risen from £3,688 in 1892 to £5,057 in 1893, and the salaries paid from £1,789 to £2,248. The expenditure upon house-keeping has risen from £336 to £376, Uniforms from £276 to £418, Sundries from £96 to £151, the total expenditure of the year 1893 being £4,530, as against £3,895 in the previous year.

The payments made to the Royal National Pension Fund in 1893 have largely increased, partly because of the wider operation of the rule made in 1892 that every Nurse engaged by the Institution should take out a policy with the Fund for an annual pension of £7 10s., the Institution on its part taking out a policy for the benefit of the Nurse, and partly because the policies already taken out by the Institution on behalf of Nurses have been so altered as to secure for them a yearly pension of £11 5s. instead of £7 10s. as formerly, thus placing the Institution Nurses upon the same footing as those working in the Hospital. The amount required to bring the policies up to this level was about £140, and there will, of course, in future years be some increase of the yearly premiums payable under this head.

The most important event of the year has been the establishment of a Bonus Scheme, in accordance with which, after such provision has been made for repairs, depreciation, improvements, etc., as the Treasurer in his discretion may deem expedient, the profits of the Institution at the end of each financial year are applied for the benefit of the Nursing Staff.

For the information of those who are not familiar with the management of the Institution, it may be well to state what are the existing arrangements for the payment of its Nurses; and this is perhaps the more necessary, as some misapprehension on this point appears to exist in the minds of the public, and even of the medical profession. It should be premised that in addition to the actual salaries mentioned below, an Institution Nurse is supplied with uniform, has her washing and medical attendance free, and that, whenever she is not employed upon a case, she has a home provided for her, without expense, in the Institution.

A Nurse, whilst she is a probationer, receives a salary of £12 for the first year, and £18 for each of the two succeeding years; when she has completed her training, and is placed upon the permanent Nursing Staff, she receives £25 for the first year, £30 for the second year, £35 for the third year, and £40 for the fourth year, after which she is not entitled to any further increase. In addition to this salary the Institution takes out for her a policy in the Royal National Pension Fund for Nurses, to produce for her an annual pension of £11 5s. at the age of fifty years, the Nurse herself being required to take out a policy for £7 10s. at the same age.

The Bonus Scheme recently introduced provides for the division of the surplus profits as above defined amongst those Nurses who have been on the Staff of the Institution for four full years subsequently to the completion of three years as Probationers. The money is not, however, paid directly to the participating Nurses, but is invested for their benefit with the Royal National Pension Fund for Nurses for the purchase of pensions to begin at the age of fifty-five; nor are Nurses allowed, under any circumstances, to obtain possession of the sums annually invested for their benefit in the Fund, though, should a Nurse die before attaining the age at which her pension falls due, the money standing to her credit will be paid out of the Fund to any person whom she may nominate; or if she should become permanently incapacitated from following her avocation as a Nurse, the money may be applied towards her maintenance or for her benefit in such manner as may be thought expedient.

The surplus profits forming the Bonus Fund are divided on the following basis:—A Nurse who has completed five years of service receives four shares in the Bonus Fund for that year; six years of service receives five shares in the Bonus Fund for that year; seven years of service receives six shares in the Bonus Fund for that year; eight years of service receives seven shares in the Bonus Fund for that year; nine years of service receives eight shares in the Bonus Fund for that year.

After the completion of the ninth year a Nurse continues to receive eight shares each succeeding year of her service until she attains the age of fifty, when the bonuses cease, but as above stated, she becomes entitled to her own pension of £7 10s., plus the pension of £11 5s., for which the Institution has paid the premiums. The superannuation age has been fixed at fifty-five, unless, under special circumstances, it is decided to retain the services of any particular Nurse after that age.

The above is an outline of the salient features of the Bonus Scheme in a form which, it is hoped, will be easily understood; but it is to be regarded only as a sketch, the instrument in which the scheme is embodied containing numerous clauses and provisions, which it is unnecessary in this place further to specify. Nurses, however, and those interested in the details of the scheme, should obtain a copy of the documents by application to the Lady Superintendent. It is believed that the profit-sharing scheme thus outlined is, in a great measure, novel, so far as nursing institutions are concerned. The plan has been the subject of much anxious thought, and has been drawn up after very careful consideration of the conditions under which Nurses carry on their profession. Amongst other obvious advantages it appears to be consonant with the sound principle that the earnings of Nurses should be equitably divided amongst themselves, and at the same time to afford adequate security that these earnings should be so utilized as to furnish due provision for their declining years.

The profits of the past year have been sufficient to allow of a division of the Bonus Fund amongst those Nurses who are of standing to participate in it at the rate of £5 a share. The Treasurer takes this opportunity of thanking the courteous Managers of the Fund for the ready assistance afforded him in carrying out this further extension of their excellent system.

During the past year the two Maternity Nurses who are maintained by the Institution have attended 198 cases, and paid 3,193 visits, in the districts embraced by the Lying-In Charity of Guy's Hospital. The following table shows the number of cases attended in each parish within that area:—

Name of Parish.	Number of Cases.
St. Saviour's, Southwark	36
St. George's, Southwark	36
Bermondsey Parish...	49
St. John's, Horselydown	25
St. Olave's, Horselydown	19
Newington Parish	16
St. Paul's, Nelson Street	6
St. Saviour's, Bermondsey...	4
St. Matthias, New Kent Road	2
St. Mary's, Newington	2
Holy Trinity, Trinity Square, S.E. ...	2
Christ Church, Bermondsey	1
Total...	198

The Treasurer is glad to say that a liberal response was made to last year's appeal on behalf of the Maternity Samaritan Fund, the object of which is to provide clothing, food, coals, and other necessaries for destitute mothers at the time of confinement. When it is remembered that the district in which these families live is, as Mr. Charles Booth has shown, one of the poorest and most wretched in the whole of London, the Treasurer feels sure that he will not appeal in vain for continued assistance, in the way of money or presents of linen and old clothes, to enable the Lady Superintendent to carry on her charitable efforts in this direction.

The following is a list of the donations and subscriptions received last year:—

	£	s.	d.
Samaritan Fund of Guy's Hospital ...	10	0	0
Collection—Hospital Chapel	5	0	0
Miss Cotton...	5	0	0
Mr. Oswald Smith...	5	0	0
Miss Barron	2	2	0
Mr. Ablitt	2	2	0
Mr. C. C. Swift	2	2	0
Mrs. Montefiore, per Mr. H. Durham ...	2	2	0
Mr. J. Anderson	2	2	0
Mrs. Ellis de Versin	1	1	0
Sir C. Fremantle	1	1	0
Miss James	1	0	0
Dr. Perry	1	0	0
Mrs. J. Anderson, per Mr. Carpmael ...	1	0	0
Miss Bavier...	1	0	0
Nurse Elders	0	10	6
Miss E. James	0	10	6
Miss Carpmael	0	10	0
A Friend	0	10	0
Mr. Brown	0	10	0
Miss Taylor...	0	5	0
Sister Cornelius	0	5	0
Sister Job	0	5	0
Miss Hibbling	0	4	6
In smaller sums	0	6	6
	£45	9	0

Gifts of clothing and bed-linen, old and new, have been received from Mrs. Friedlander, Mrs. Harvey, Lady Hartford, Sister Miriam, Mrs. Perry, Mrs. Maclean, Mr. Floyd, Sister Mary, Mrs. C. C. Swift, Nurse Parrett, Messrs. Swan & Edgar, Mrs. Milbourne, Nurse Pearse, Sister Cornelius, Miss B. M. Swift, Miss Morritt, Miss Strick, Sister Bright, Nurse Evans, Mrs. Henderson, Mrs. Shaw, Nurse Steer, Nurse Blake, Miss Fricker, Mrs. Kirby, Miss Buckton, Miss Lafone, Miss Dawe, Nurse Gossage, Mrs. Schwarz, Miss Loy, Miss Cumberland, and Mrs. Goss.

On the following page a statement of the receipts and expenses in connection with the Maternity Samaritan Fund. Contributions, whether of money or clothing, for the Fund will be gratefully acknowledged by Miss Sarah A. Swift, 14, St. Thomas's Street, London, S.E.

Receipts and Expenditure in connection with the Maternity Samaritan Fund for the Year ending December 31st, 1893.

	£	s.	d.
To Balance from last year	1	6	0
Subscriptions and Donations	45	9	0
	£46	15	0
By Milk, Meat, Eggs, Groceries and Coals ...	14	8	11
Stimulants	1	1	8
Clothing, Sheeting, &c.	13	1	6
Printing and Posting	0	10	0
Balance in hand	17	12	11
	£46	15	0

Receipts and Expenditure in connection with Guy's Hospital Trained Nurses' Institution for the Year ending December 31st, 1893.

	£	s.	d.	£	s.	d.
To Balance from last Account				662	7	6
„ Fees received for Nurses' Services, &c....				5,057	10	8
				£5,719	18	2
By Housekeeping	376	15	11			
„ Stationery and Advertising	100	0	9			
„ Telegrams, Stamps and Travelling	68	0	8			
„ Laundress	104	6	8			
„ Salaries	2,248	14	10			
„ Uniforms	418	4	9			
„ Rents, Rates and Taxes ...	357	10	6			
„ Furniture and Repairs ...	14	11	9			
„ Board and Uniform of 12 Probationers at Guy's Hospital	380	0	0			
„ Pension Fund	207	10	1			
„ West End Branch	101	8	0			
„ Sundries	151	7	5			
				4,530	11	4
„ Balance forward—						
On Loan to the Medical School	500	0	0			
On Loan to Lehay & Co.	250	0	0			
Balance at Bankers ...	409	7	4			
Petty Cash	29	19	6			
				1,189	6	10
				£5,719	18	2

I have examined the above Accounts, with Vouchers, and found the same to be correct,

H. B. BRIGGS, Auditor.

London, February 16th, 1894.

1st Conjoint Examination, April, 1894.

Under Old Regulations.

Elementary Anatomy and Physiology.

Ashby, E.
Clarke, W. E. J.
Crapper, H. S.
Handson, L. E. C.
Morgan, T.
Oliver, N. H.
Payne, J. L.
Penrose, A. W.

Elementary Anatomy only.

Cogan, L. D. B.

Chemistry and Chemical Physics.

Davies, E. C.
Knight, F. C. R. M.

Materia Medica and Pharmacy.

Collier, H. N.
Turner, A. Scott.
Watson, C. E. S.
Winter, W. C. P.

Under Regulations dated January 1st, 1892.

Elementary Anatomy and Biology.

Baker, W. L.
Bent, V. T. C.
Berncastle, H. M.
Chapman, C. L. G.
Crawford, V. J.
Dyson, J. N.
Evans, E. A.
Goddard, E. G.
Hewlett, C. J.
Howells, J.
Lewis, A. D.
Longhurst, E. A.
McGavin, L. H.
Martin, F. J. H.
Michell, R.
Mussellwhite, W.
Nourse A. W.
Pennington, S. B. A. C. C.
Reid, A.
Richardson, W. S.
Row, E. R.
Saward, A. H. M.
Shenton, E W. H.
Sturdy, H. C.
Thomas, A. R.
Thomson, C. B.
Walker, T. M.

Elementary Anatomy only.

Alexander, K. B.
Andrew, E. G.
Barron, R. M.
Barrow, H. P. W.
Batchelor, H. C.
Berry, T. P.
Dupigny, J. E.
Durbridge, H.
Eason, H. L.
Featherstone, F. R.
Fowke, W. C.
Fox, H. E. C.
Johnson, W. J.
Kirkman, A. H. B.
Lewis, A. C.
Marriott, O.
Miller, A. A.
Milton, W. T.
Mules, J. H.
Outred, C. D.
Powell, J. E.
Read, A.
Ruzzak, S. A.
Shepherd, C.
Telling, W. H. M.
Turner, P.
Walker, F. E.
Westlake, B. B.

Elementary Biology only.

Bignold, H. H.
Churchill, G. B. F.
De Coteau, J. T.
Humphry, L.
McIlroy, W.
Roberts, J. H.
Sells, C. B.
Tongue, G. J.
Turner, H. S.
Watson, C. F.

Chemistry and Physics.

Davis, E. I.	Mules, J. H.
Dupigny, J. E.	Nourse, A. W.
Fox, H. W.	Thomas, A. M.
Harrison, S.	Tongue, E. J.
McIlroy, W.	Walker, T. M.

Watson, C. F.

Practical Pharmacy.

Berry, T. P.	Mussellwhite, W.
Chapman, C. L. G.	Ruzzak, S. A.
Dupigny, J. E.	Telling, W. H. M.
Landon, T. W. H.	Thomas, A. M.

Walker, F. E.

From the Gazette's Special Pathologist.

T. C., Braintree.—Early cylindrical celled carcinoma of the breast.

C. G. R., Hadstead.—Small spindle celled sarcoma.

C. D. M., Bournemouth. — Encephaloid spheroidal celled carcinoma of breast.

I. A. B., Ryde.—Aden's carcinoma.

F. S. B., Malpas.—Tubercle bacilli present.

H., Caterham Valley.—No tubercle bacilli observed.

S. C. S., Walthamstow.—No tubercle bacilli observed.

C., Bletchenley.—Tubercle bacilli present.

A. W., St. Leonards.—Tubercle bacilli present.

T., St. Leonards.—No tubercle bacilli observed.

M. V. R., Fordinbridge.—Tubercle bacilli present.

H. E. C.—No tubercle bacilli observed.

H., Reigate.—Tubercle bacilli present.

C. D. M., Bournemouth.—Tubercle bacilli present.

W. R., Blackheath.—No tubercle bacilli were recognised in specimen sent.

PATHOLOGIST.

Specimens for examination and description in this column, should be addressed to H. Hunt, Gazette, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

Recent Additions to the Library of the Students' Club.

Splendid Spur. Q.
Adventures of Harry Richmond. Meredith.
Noughts and Crosses. Q.
Dead Man's Rock. Q.
Twenty Years' After. Dumas.
Vicomte de Bragelonne. Dumas.
Journal of Voyage to Lisbon. Fielding.
Heine's Works. 3 vols.
Mermaid Series. 17 vols. of the best plays of the old dramatists.

Recent Additions to the Hospital Library.

Talaman's Appendicitis.
Bland Sutton on Tumours—Innocent and malignant.
Matthews Duncan's Clinical Lectures. Latest edition.
Radcliffe Coocker's Atlas of Skin Dlseases,—as issued. A fasiculus every two months.
Lavers' Diseases of Women. Latest edition.
Foster's Physiology. Part I. Sixth edition.
The Journal of Pathology and Bacteriology has been added to the list of journals regularly received at the Library.

Presentations.

Taylor's Principles and Practice of Medical Jurisprudence 2 vols. New edition. By the editor, Dr. Stevenson.
Lauder Brunton's Introduction to Modern Therapeutics. Dr. Stevenson.
Griffith & Henfrey's Micrographic Dictionary.
Berry Hart's Selected Papers in Gynæcology and Obstetrics. By the Publishers, Messrs. A. & K. Johnstone.
Berry Hart's Topographical and Sectional Anatomy of the Female Pelvis. By the Publishers, Messrs. A. & K. Johnstone.
Cathcart & Caird's Atlas of Ligaments and Bones. By the Publishers, Messrs. A. & K. Johnstone.
Hunter Mackenzie on the Sputum. By the Publishers, Messrs. A. & K. Johnstone.
Proceedings of the Laryngological Society of London.

Correspondence.

To the Editor of Guy's Hospital Gazette.

United Hospitals' Cycling Association.

Dear Sir.—On the 21st of March a meeting was held at Guy's, at which representatives from four of the London Hospitals were present, and, amongst others, the following resolutions were passed:

1. That a United Hospitals' Cycling Association be at once formed.

2. That its management be entrusted to a committee consisting of two representatives from each hospital joining in the Association.

3. That the object of the Association be to arrange inter-hospital race meetings and united hospital runs, and to generally further the interests of cycling among medical students.

4. That hospital cycling clubs can join as a whole, or individual students may become members.

Full particulars of all fixtures, and any further information I shall be pleased to send on application,—I am, dear sir, faithfully yours,

H. J. MILBANK-SMITH, Hon. Sec.

Physical Exercise.

A Paper read before the Physical Society, January 20th, 1894, by Mr. F. J. Steward.

(Concluded.)

The effect of moderate exercise in improving the general tone of the nervous system is so patent as to need no discussion here. The effect, however, of systematic severe exercise on the mental condition is not so evident. Does a large expenditure of energy on the part of the muscles diminish the amount available to the nervous functions? In answer to this, it is well known that functional activity, whether of mind, or muscles, or of any other part of the body, depends on the amount of work performed, and the natural tendency of any form of life that cultivates the purely physical, to the almost total neglect of the mental powers, must be to induce deterioration of the latter. It is also well known that over-training produces a condition of general depression, leading to mental inactivity as well as physical. The question, however, whether carefully regulated exercise leads to aversion to, or disqualification for mental work, is one which much more directly concerns ourselves. The careful investigations of Clarke, of Oxford, and Morgan, show that the men, both of Oxford and Cambridge Universities, who go in for athletics, have obtained more than their proportional share of Academic honours. We must also remember that the amount of exercise taken needs a concomitant increase of nutriment, and since exercise itself increases the digestive powers, this increase of nutriment cannot but lead to a general increase of nutrition of the body in toto, and with this also of brain, and so of the mental faculties.

The effect on the actual expenditure of nervous energy during the exercises is also worthy of notice. For, by systematic exercise, groups of muscles, which were formerly estranged, are brought into correlation, so that movements, formerly complex and difficult, are carried out with ease. The result is a saving of energy to the brain, for thus acts which were performed with conscious mental effort become automatic; and this automatism is one of the most striking results of regular exercise, for, as time goes on, the work gets easier and easier, not only from increased strength, but also from the greater ease with which the muscles concerned act in co-ordination, and thus the end desired is attained with the least expenditure of energy. We must all have experienced this, how, in beginning any new form of exercise, the chief difficulty is stiffness and want of ease, because we have not yet learnt how to balance one group of muscles against another in the new acts performed. Again, on first riding a bicycle, one expends as much energy in riding one mile as a month later will be required to ride five or ten miles. Just as the muscles increase in power, so the whole nervous mechanism is improved, for, just as secondary degeneration occurs in nerves, and cord after the removal of a limb, so the same become elaborated when that limb is brought into more systematic use. Physical exercise, in my opinion, is also of great use to the mind, especially with regard to volition. For we know that any severe and prolonged exercise, especially when pushed to the point of fatigue, demands a vigorous exercise of will-power. Such increased exercise of *will* must needs instil the feeling of increased *will-power*, and so begets self-confidence and resolution. In this connection, Plato's observations on the physical education of the Greek youths are interesting. He says, "The toils and exercises, if overstrained, make men hard and brutal, but, if properly regulated, stimulate the spirited element of their nature, make them valiant and discipline their powers."

Let us now turn to the second part of the subject, namely, the consideration of the pathological lesions ascribed to Physical Exercise. The most common ill effect of prolonged or excessive work on the muscles, without sufficient rest, is a condition of chronic exhaustion causing paresis, and later on leading to atrophy. These effects are, as a rule, only seen in a small group of muscles; since in the cases where the exercise is more general, constitutional exhaustion and prostration occur long before such extensive mischief can be done to the muscles themselves. Writers', violinists', tailors' and milkers' palsies are well-known examples of this condition: a less common instance is miners' nystagmus, which occurs in miners with weak ocular muscles who constantly work in the dark. Onwins gives an interesting account of a draper's assistant, whose work chiefly consisted in replacing packages on the shelves of the shop; when he sought advice he was suffering from atrophy of both deltoids. Another case which he mentions was that of a leather-worker who had constantly to move his arms backwards and forwards in preparing the leather; he suffered much from fatigue, and after a time it was found that certain muscles of both arms were atrophied. Dr. Chambers also describes an interesting case: the sufferer was a maiden lady who for a long time had been accustomed to take no more exercise than was necessary to keep soul and body together, till one fine day, feeling very energetic, she mowed her lawn, with the result that she suffered for a long time from painful loss of power in her right deltoid and biceps muscles. Muscles and tendons may also be partially or completely ruptured during any severe exertion—tennis players' leg and riders' thigh being familiar examples.

The lesions which may be produced in the various parts of the vascular mechanism are both interesting and important. Now, it is well known that aneurysm as the result of degenerate vessels usually occurs at those points where the arteries are most liable to be affected by strain. Again, during fœtal life, when endocarditis occurs, it is commonly the right side of the heart which is affected; this is explained by the fact that during this period of our existence the right heart does most work and is subjected to most strain. It is for a similar reason that the left heart is most commonly affected by endocarditis

in extra-uterine life. Disease of the right heart, as a result of mitral disease and lung troubles, and atheroma of the pulmonary arteries, and right heart disease in cases of mitral constriction, also show the effect of increased strain. Virchow was the first to point out that in aortic disease the mitral valve is frequently affected secondarily, owing to the increased force of contraction of the hypertrophied left ventricle, causing an increased strain on the mitral valves. Now, the cardio-vascular lesions caused by exertion can all be explained in exactly the same way—that is to say, they are all the results of increased strain on the various parts of the circulatory system. Take the case of the blacksmith: in using his hammer, he not only uses his arms but nearly the whole of the muscles of the body, in order to give the greatest force to the stroke. This general muscular contraction leads, as before shown, to increased arterial resistance. This increased resistance in course of time leads to hypertrophy of the left ventricle, with an increased force of beat, so to increased recoil and strain on the aortic valves every time they are closed. The result of this increased strain is a parenchymatous hyperplasia—that is to say, a slow formation of embryonic connective tissue in the substance of the valves—this contracts and so the valves become crippled and incompetent; the edges of the valves also become glued together, and so stenosis is produced.

Pouching, or aneurism of the first part of the aorta takes place at the same time, and this, of course, materially assists in the production of aortic regurgitation. The effects in aorta and other arteries are similar. The chronic distension leads to loss of elasticity, with secondary endarteritis, set up by the continual irritation, and finally giving way and aneurism, especially if the inner coat has been previously torn by a violent effort. The points mostly affected are again those on which the greatest amount of strain falls, such as the outer side of the aortic arch, points of junction of vessels, and flexures.

A point in favour of this mechanism, is the fact that aortic disease is so very much more common in men than in women, supported by the second fact that Bamberger found that in Vienna, where much of the coarser work is done by women, a much larger proportion of the cases of aortic disease occurred in women.

Dr. Moxon says, "that what is called atheroma of arteries is sub-inflammation of various degrees, of which the lower degrees end in fatty degeneration of the coats along with inflammatory products, and that the determining cause of the occurrence of this change mechanical strain."

Repeated over-strain leads also primarily to dilatation, with or without hypertrophy of first the right and then the left ventricle, this order being determined by the aforesaid difficulties under which the pulmonary circulation is placed. The above statements are, however, denied in their entirety by some observers; for instance, Schrœtter says that such changes never occur in a previously normal heart, and that their occurrence is evidence of previous degeneration; and certainly they often are seen where alcohol, bad food, etc., have acted as obvious predisposing causes.

Extreme over-exertion may also produce rupture of a valve, the aortic valve being the one most commonly affected, or a crack in the inner coat of the aorta laying the way to a subsequent aneurism, or to a condition of acute dilatation which, Dr. Clifford Allbutt says, generally but not necessarily occurs in cases of previously degenerated cardiac muscle. Another very common result is irritable heart, where the heart exertion causes palpitation, faintness, dyspnœa, and irregular pulse; and a large number of such cases in soldiers have been ascribed to prolonged marches with insufficient food.

Dr. Peacock gives a long list of similar cases, which have occurred amongst the copper miners in Cornwall, and where impure air probably acted as a predisposing cause, and the men had to climb long ladders with heavy loads. According to Hünzinger also, the prevalence of such conditions in Tubingen is owing to carrying heavy loads up the mountains. Several such occurrences have also been recorded among pedestrians and long-distance runners. In this connection a controversy took place in 1867, with reference to rowing. It was begun by Skey, who stated that boat-racing was most injurious, both in its immediate and remote effects. Subsequently Dr. Hope made the alarming statement that boat-racing was a more efficient cause of heart disease than any other known, rheumatism not excepted. In 1873 the subject was revived by the Clinical Society. At this meeting, the following are some of the cases quoted and opinions expressed:—

Dr. Clifford Allbutt said he found cases of irritable heart the most common and most difficult to cure. He described the case of a professional runner with dilated right heart, who he had under treatment for three years. He said that he thought that athletics were not so dangerous as the heavy labour of the artisan, the probable explanation being that in the latter there was less time for repair, work being carried on in spite of fatigue, diminished health, and improper food.

Dr. Douglas Powell described the case of a bargeman who had a heavy job extending over forty-eight hours, dyspnœa developed shortly afterwards, and he died in two months, with a dilated left ventricle, atheroma of the aorta, and aneurism of one sinus of Valsalva. He thought that in this case the heart must have been weakened in some way previously.

Dr. Nathan, at the Haslar Hospital, found that sixty-five out of eight hundred and fifty cases of heart trouble were due to strain, there being no history of rheumatism. He showed further that morbus cordis was on the increase in the Navy, the probable reason being the increased size of the ordnance.

Dr. Ogle had seen an oarsman at Oxford taken from his boat with violent hæmoptysis. In the same year as this meeting, Dr. Morgan published his statistics relative to the after history of men who had rowed in the University boat races. Out of two hundred and ninety-four oarsmen, there were only seventeen instances

of injurious consequences, the chief of which were three deaths from heart disease, one death from acute pneumonia said to have been due to a chill after rowing, one case of hypertrophy and dilated heart, another of irritable heart, preventing ordinary employment, and three cases of general break-down or passing from a very active to a sedentary life. This seems a very small list, still it must be borne in mind that the men engaged in these races are picked men, and have been carefully trained, and if similar data could be obtained from the various scratch races, etc., in which inferior men often take part, the percentage would very probably be considerably higher. Considering, however, the large number of men who do go in for rowing, it is remarkable what a few cases of evil consequences have been reported if boat racing is really so dangerous as the above statements would lead one to suppose. With regard to running, Walter Rye, the well-known authority on cross-country running, says: "We can speak from an experience now covering nearly twenty years, and can say positively that we know of no man of the hundreds with whom we have been acquainted who has been injured by distance running, and the rate of mortality amongst running men is singularly small."

Besides the above lesions, hæmorrhages of various kinds have been recorded, and have been met with in almost every part of the body, as a result of exertion. Lagrange mentions a case of paraplegia resulting from rupture of the spinal veins, during extreme muscular effort.

With regard to aneurysm, an interesting point is, that the age at which it is most common, is above that during which large amounts of exercise are usually taken. This seems to me a strong argument against men over thirty taking sudden and violent exercise when out of condition.

Varicose veins are said to be a common result of exercise, but there is no evidence to show that they are relatively more common in athletes than other men; moreover, varicose veins are far more common in women than in men. If, as Mr. Bennett states, they are due to some inherent tendency, exercise may act as the actual exciting cause in some cases. With regard to the lungs, hæmoptysis and emphysema are said to occur, but I do not think they can be very frequent results.

Bones have been fractured by violent muscular effort, especially the clavicle and the humerus; but Treves says that in many instances the bone has been proved to have been previously diseased.

Hernia is stated by some authors to be a frequent result of exertion; but in those with well-developed muscular symptoms, hernia is comparatively rare, and even in professional gymnasts and acrobats, in spite of the immense muscular efforts which they make, rupture is quite a rarity, except when they are out of condition and suddenly exert themselves to a great degree. The hernias that result from muscular exertion occur, in great part, in those whose tissues are somewhat lax, either from age, or from some circumstances such as the return to work after an illness, and so forth.

With regard to this point, Treves remarks that "carefully selected, systematic and well-adjusted exercise is the best protective against hernia, and the objections against athletics founded on the production of hernia are unjust and unsound."

There is one other condition which seems to me very interesting: it is what Dr. Knott calls the fever of overexertion. This begins with headache, general weariness, loss of appetite, and inability to sleep, together with febrile symptoms. One of Dr. Knott's cases was as follows:—The sufferer was a greatly overworked farm labourer. His symptoms began with a rigor, the temperature rose to 104°, and was accompanied by all the usual symptoms of fatigue, combined with those of high fever. After keeping in bed for a couple of days, he was apparently well, but on returning to work, a recurrence of all the symptoms took place. At length, though able to do a little work, his temperature remained constantly at about 101°, the pulse was permanently quickened, he suffered from thirst, constipation and wasting, and his urine was loaded with urates. Dr. Knott ascribes these phenomena to the throwing into the circulation of a greatly disproportionate amount of waste products which he says, at first temporarily, and then permanently, upset the thermo-taxic mechanism. Dr. Lagrange describes a similar sort of trouble, and agrees with Dr. Knott as to its cause.

This, gentlemen, concludes what *I* have to say, but I hope to learn a great deal about the many other aspects of the subject from what *you* are going to say.

Births.

HUDSON.—On April 7th, at Vine House, Cobham, Surrey, the wife of Arthur Byon Hudson, M.R.C.S., L.R.C.P., of a son.

PESKETT.—On March 25th, at Leyton, Essex, at the residence of her brother, the wife of A. W. Peskett, M.A., M.B., B.C. Cantab., of a son.

ROBERTS.—On April 1st, at the Beeches, Lowestoft, the wife of Reginald J. Roberts, B.A., M.B., B.C., of a son.

Marriage.

DEANE—PRALL.—On April 3rd, at All Saints', Carshalton, Edward Deane, M.R.C.S., of Caversham, Reading, to Emma Elly, eldest daughter of the late Dr. Prall, of West Malling.

Deaths.

LANSDOWN.—On April 2nd, at Samber House, Clifton, Bristol, Elizabeth Blaker, wife of Francis Poole Lansdown, surgeon.

ROBERTS.—On the 9th April, at the Beeches, Lowestoft, Catharine Sarah Katie, wife of Reginald J. Roberts, B.A., M.B., B.C., and daughter of George Kett, Esq.. J.P., Wymondham House, Cambridge, aged 30.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual subscription to the Gazette *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers, who may be desirous of having their numbers of the Gazette *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette,

APRIL 28, 1894.

A Guy's Clinique.

OUR readers may perhaps feel that they have already suffered a great deal from editorial efforts to bring forth efficient reports of cases and teaching in the wards; some because, by diverse devices, they have been worried to contribute, and a larger number because they have been presented with reports which have possessed but little uniformity of design or continuity of method. This latter shortcoming we are determined to rectify, but the former offence we shall continue to commit; if needs be, in greater measure.

We aim at becoming purveyors of a complete Guy's Clinique. If we succeed, we shall probably be the first journal to carry out any such enterprise continuously and systematically, and we mean to try.

That the scheme would prove acceptable we have now the fullest evidence, and it would gain us support (did we need it) even outside the Guyite community.

Many of the Staff have already expressed their approval of the scheme, and will no doubt be ready to advise our reporters when consulted by the latter. The Registrars have also promised to give all the assistance in their power as regards choice of cases and other details. But we urgently desire that our ward columns shall not be confined to a list of interesting cases. It should comprise also the salient points of the teaching which the cases call forth. There is probably no clinical teacher who will hesitate to admit that he is most inspired when actually in the presence of cases. It is then that his memory dives deepest into his experience, and he can then teach with a vividness which may be absent from the formal lecture of the theatre. Yet these bedside lecturettes, with all their merits, are lost, save to the privileged few, whose position for the time being enables them to frequent the wards at the time of going round.

It may be that our teachers will feel some little dread of suffering at the hands of more or less inexperienced reporters; but we hope in all cases to submit proofs for their approval.

We have hitherto tried to obtain our material from some individual reporter selected from each group of dressers or medical ward clerks, but we intend, in this respect, to make a new departure.

For the future there will be found in each ward a supply of printed forms which may be filled up for the purposes of the Gazette. We hope that these may serve as a constant reminder to each dresser or medical ward clerk who may have an interesting case under his charge, that ten minutes spent by him in filling up one of these forms with the salient features of his case and the teaching it may have evoked, will be of the greatest benefit to hundreds of our readers.

One member of the Staff suggested the other day, that Burns' "A chiel's amang ye——" would be a suitable motto for our ward column. We shall certainly adopt it when the chiel gives us plenty to "prent."

We are aware that we are asking a great deal from overworked students, but we venture to think that the effort required will be small compared with the value of the results which

may follow. We are haunted indeed by the wretched old saw, "what is everybody's business is nobody's business," but hope nevertheless that our readers will enable us to escape from its application.

If the present medical ward clerks and dressers will launch our venture properly, we make no doubt that their successors will emulate their efforts and keep it afloat. This is for the *xth*, but *not* for the last time of asking.

The Eleventh International Medical Congress.

The Eleventh International Medical Congress has been held at Rome, and the ancient city has again returned to its wonted calm. In some respects Rome is the most unsuitable of all possible cities for a Medical Congress, for the influence exerted by the visible records of two thousand years is strongly against the turning of one's mind to the discussion of the hurrying medicine of the present day. The mighty past cannot but dwarf for a brief period the almighty present, for although the strides that medicine has made in this century are great ones, yet in the light of the past they are the uncertain steps of a giant infant rather than the purposeful march of the grown man. The truth of the old saying "that all roads lead to Rome" was borne out by the number of visitors that were attracted, firstly to Rome, and lastly to the Congress; for whilst the Italian Committee made excellent arrangements for about fifteen hundred "Congressists," Rome had to accommodate between eight and nine thousand visitors, who eagerly sought after tickets for all the fêtes; who thronged the museums and the galleries; who worshipped in the churches and attended lectures at the Forum Romanum; who wearied the Trappist monks in the catacombs and gazed with awe at the thermæ of Caracalla, and trod with reverence the Appian way; and some of whom even ascended the Scala Santa on their knees.

It was truly remarkable how constantly one was meeting distinguished foreigners everywhere but at the Polyclinic, where the papers were read and the discussions took place. This being the case, it is not to be wondered at that the number of papers of first importance and of exciting medical discussion was but small, and that the discussions that were constantly taking place everywhere else than at the Polyclinic were chiefly concerned with the difficulty of obtaining invitations to the garden party at the Quirinal, with the overcrowding at the reception at the Capitol, and with the difficulty of getting a good view of the illuminations at the Colosseum. The only time that the Polyclinic could be said to have been crowded was on the day on which most of the invitations to the fêtes were distributed, and the only part of the Congress building which was always full was the bureau where letters were called for.

The Congress itself could much more fitly be spoken of as a congress of Italian doctors, with a sprinkling of foreign visitors, than as an international congress. The large majority of the papers were by Italians, and the chief speakers at the discussions were Italians.

The section which was perhaps best attended by foreigners was that upon Pathology, where most interesting discussions upon cancer and upon malaria took place; of the other sections, those dealing with children's diseases and with military hygiene were perhaps most important in respect of the value of the papers communicated.

At the close of the Congress one heard on all sides the opinion expressed that the attempt to combine a Congress on Medicine with seeing Rome was a failure, in that the strain was too great. Everyone agreed that it had been impossible to do both, and almost everyone acknowledged that this truth had been borne in upon them on the first day of the meeting of the sections, and that they had then given up the Congress and devoted all their energies to seeing Rome, perhaps wisely.

Undoubtedly, the moral to be drawn is that the most suitable place for an International Congress would be that place where the local surroundings are the least interesting, so that the temptations are limited, and perhaps also where the attractions to guests and to doctors in search of a holiday are fewest.

Before leaving the subject, it is only fair to say that in one respect the Congress was a great medical success, and that was in the extremely valuable exhibition of apparatus and appliances relating to medicine and hygiene. This exhibition was not only most complete, but it afforded a most interesting study of the appliances used by different nations for the care of the healthy and of the sick, and for the cure of the latter. The English exhibits were comparatively few, but those that were shown were all good; and throughout the greatest care had been taken to make the collection as complete and as instructive as possible.

If the general impression of the medical aspect of the Congress is one of disappointment, those who took part in it can but have a strong feeling of gratitude for the great kindness of their hosts, and must have brought home memories which must be an undying source of pleasure to them in the future, even as they have been a source of happiness to them in the past.

Short Sayings of Great Men.

More lives have been saved by the use of artificial human milk and opium than by any other means.

What splints are to the limbs, atropine is to the eye.

A Fatal Case of Raynaud's Disease

In a Girl having Mitral and Tricuspid Stenosis, Pericarditis, Acute Cardiac Dilatation, Pneumonia, Embolism of the Brachial Artery, and Atrophy of the Muscles of the Feet.

CLINICAL LECTURE BY W. HALE WHITE.

(Concluded.)

Now, we have left to explain the gangrene of this patient's feet, which was, I think, due to Raynaud's disease. We had better, therefore, try and get a clear idea exactly what is meant by this.

Raynaud's disease in its typical form is a malady in which, from time to time, the fingers, toes, and occasionally the nose and ears, or rarely other parts, become symmetrically painful, cold and livid. It is essentially paroxysmal, there are long intervals during which there is nothing the matter with the parts which at other times are affected with recurrent paroxysmal attacks of the malady. The attacks vary much in severity in the same patient and among different patients. Sometimes they are little more than the lividity and coldness of the hands that all of us are subject to in cold weather, sometimes they pass on to gangrene of the affected parts. Let us now run over the points of Raynaud's disease and see if our case showed them.

1. *The symmetry of the affection.* — This is very characteristic, although not essential. It is rarely absolute, but still it is very exceptional for one hand to be affected and the other free. In our case the fact that the toes on both feet were implicated was very suggestive of Raynaud's disease, and the circumstance that the arm on one side only was affected, pointed to the fact which the absence of pulsation in the brachial confirmed, that the condition of the arm was not due to Raynaud's disease. The symmetry of the living patch in the gluteal region suggested that this was related to Raynaud's disease.

2. *The state of the parts.*—In the mildest degree of the malady the affected part all at once becomes pale and cold. The patient says it feels dead. Its cutaneous sensibility is lowered, it feels cold and is cold, as may be shown by the thermometer, and drops of sweat may appear. This condition may last a few minutes or a few hours, and in the period of reaction the area implicated flushes, and is red and painful.

In the next degree of severity the parts are of a cyanotic blue, they may present all depths of colour from a bluish white to slate coloured or black. The colour may be uniform or there may be much mottling of the blue with dusky red patches. I show you drawings from a patient you may remember in the Mary ward, giving a very good idea of the condition of things. The pain—often shooting and burning—and the numbness cause the patient to complain much. As the attack gradually passes off the lividity disappears, and a vermilion border appears at the edge of the affected parts. The degree of severity here described is very usual and typical, and is called by Raynaud one of local asphyxia. Sometimes the fingers or toes are a little swollen, but there is never the clubbing seen in the lividity associated with disease of the chest.

In the next degree of severity the local asphyxia does not pass away, and gangrene supervenes. The extent of this is variable; a very common condition is for only the tips of the fingers or toes to be gangrenous, there being little patches of gangrene on their pulps, a gangrenous ulcer forms here, and leaves a small permanent scar which remains for years after the local asphyxia has passed off, so that these little scars are very typical of previous Raynaud's disease. This drawing shows them well. If a large area, such as several fingers, become gangrenous, the gangrene is usually ultimately dry, the mummified parts assume that dark mahogany colour which is so characteristic, and the veins are then seen as dark lines. Sometimes the nails only drop off, and sometimes bullæ filled with bluish fluid are formed on such part of the gangrene as is not yet dry. In the specimen I show you, taken from our patient, you notice the dry gangrene of the toes and the bullæ on the dorsum of the foot.

3. *The history.*—The patient usually tells us that she has often suffered, especially in the winter, from attacks of cold livid hands and feet, and you will remember that our patient said she was so liable to them that they even occurred in the summer. This is very characteristic of Raynaud's disease.

4. *Parts affected.*—These are commonly the fingers, toes, alæ of the nose, and ears, the fingers and toes being very much more common than other parts. In our case it was the toes that were principally affected, but she also illustrates that the lividity rarely may begin on any part of the body, for the symmetrical patch on the gluteal region was probably part of Raynaud's disease, and here is a drawing of a patient who was in Mary ward six months ago, and who from time to time got livid patches on various parts of the body. A patient I saw in November had the ears and nose affected.

5. *The pain.*—The affected parts are very painful. Raynaud himself says that sometimes the patients how with the pain, and I see from time to time—I have seen her this week—a patient in whom the pain is fearful; when an attack is on she will not let anyone even touch her hands, although they are but slightly livid. In our patient there was much pain, but not so severe as this.

6. *The exciting cause.*—The attacks are, other things being equal, always worse in cold weather. The case I have just referred to gets them every winter, and in our patient the condition came on shortly after very cold weather. Also, the more the patient is out of health the more likely she is to get an attack. No doubt in our case the pneumonia was largely responsible.

7. *The pulse.*—The pulse can always be felt in the affected parts or right down to them if they are gangrenous. We always, in our patient, felt that both posterior tibial and both dorsalis pedis arteries supplying the toes affected with Raynaud's disease were pulsating,

but we could not feel any pulse in the brachial blocked by an embolus.

8. *The sex.*—Almost three quarters of the cases are women. The last five cases I have seen have all been women.

9. *The age.*—The patients are usually a few years either side of twenty. Four out of the five women just mentioned have been of this age, and our present patient was sixteen years old.

10. *Menstruation.*—Raynaud himself was inclined to regard stoppage of menstruation as an important cause; but I have often asked about this, and have never been satisfied myself that it is of much importance. You should note that our patient menstruated during her illness, and we constantly wondered that, being so ill, she could live so long. This is of interest, because I fancy that when patients are seriously ill and yet menstruate, it indicates a good prognosis, for it shows that the natural functions of the body are not so impaired as we might suspect.

11. *The joints.*—You will sometimes observe in patients affected with Raynaud's disease that there is fibrous ankylosis of the terminal phalangeal articulations, and that there are thickenings along the processes of the palmar fascia. These results of the disease may in time clear up. Occasionally there is fluid in the joints.

12. *Association with nervous diseases.*—Some of Raynaud's cases were hysterical, some patients I have seen have been so, and we all thought the subject of the present lecture decidedly hysterical. Several cases have also been described from asylums.

13. *Hæmoglobinuria.*—It is a well-known fact that hæmoglobinuria and Raynaud's disease may occur in the same patient.

14. *Scleroderma* is sometimes associated with Raynaud's disease.

15. Some reported cases appear to show that occasionally Raynaud's disease is associated with ague and with syphilis. I have recently seen a case associated with ague.

16. It is also very important to remember that it is sometimes associated with urticaria, with ill-defined livid mottlings of the skin, which come and go, and with a condition of the hands and feet, originally described by Weir Mitchell, and termed by him erythromelalgia, in which there are paroxysmal attacks of redness instead of blueness. This drawing shows the mottlings of the skin seen in the case we had in Mary ward, and I occasionally see a patient in whom sometimes the attacks are most like Raynaud's disease, and sometimes most like erythromelalgia.

17. *The blood.*—It is stated that the blood does not form rouleaux so well as healthy blood; this was noticed in a case which was in Miriam ward under my care in 1890.

18. Lastly, I should like to direct your attention to the fact that our patient had mitral disease. The patient mentioned above, whose attacks are so painful, also has mitral constriction. Whether this association is a mere coincidence, I cannot say, but it is curious that two at least of Raynaud's original cases also had organic heart disease.

Pathology.—You have only to read an account of Raynaud's disease, or to watch a case, to see that one factor at least in it is a constriction of the minute vessels of the affected part. Indeed, Raynaud has published two cases in which paroxysmal constriction of the retinal arteries was actually observed, and it led to paroxysms of amblyopia. We may, therefore, start with the assumption that the local syncope and the local asphyxia of Raynaud's disease are due to spasm of the minute vessels of the affected part. Of course you therefore at once say that surely the seat of the malady must be in the nervous system, and of seven published cases in which the peripheral nerves have been examined, peripheral neuritis was found in five, and you well remember the suggestive fact that local attacks of dead fingers are met with in the subjects of peripheral neuritis. At first sight the degeneration of the muscles of the soles of the feet met with in our case, made it seem, at the post-mortem, probable that we should find the plantar or posterior tibial nerves would be affected with long standing severe neuritis, in which case the degeneration of the muscles would have been secondary to the neuritis, but we did not find any severe neuritis, that which was present was quite inadequate to explain the condition of the muscles. It may be that some day we shall learn that there is a special significance in this atrophy of the muscles of the soles of the feet met with in our patient, for paralysis of these muscles has been described in one case of erythromelalgia, but for the present it seems to me wiser to regard it as evidence of old anterior poliomyelitis.

But please do not go away with the impression that you know all about Raynaud's disease when you have ascribed it to peripheral neuritis; probably it is due to it in some cases, but not only have we failed to find a marked degree of it in our case, but the two published cases in which it was not found were particularly carefully reported and examined. You will find an account of them in Dr. Barlow's translation of Raynaud's work. Then again there is the possibility that sometimes the neuritis is secondary to the gangrene, and this probably explains the slight neuritis in our case, and also it is well-known that many cases of Raynaud's disease have very few symptoms of peripheral neuritis, and lastly you must remember that local vaso-motor changes can be produced by disease of other parts of the nervous system. For instance, local dilatation of the vessels of one side of the body occurred in the man who had fits as a result of cerebral syphilis, and who formed the subject of a clinical lecture a month ago, and Dr. Fagge has described a case of malignant disease of the thorax in which some of the nerves going to the arm were pressed upon, and the fingers presented a condition very like Raynaud's disease. Also many of the cases of Raynaud's disease occur in hysterical and insane subjects. Then,

too, there is the suggestive fact that our patient may have had anterior poliomyelitis affecting the anterior cornual cells connected with the feet, perhaps this left them in an unstable condition, in some way related to the Raynaud disease of this patient's feet. So you see the right way of looking at Raynaud's disease is to take a wide view, and to regard it when marked as a symptom indicative of disease affecting some part of the nervous vaso-motor system, shading off, quite imperceptibly, into the cold, dead fingers to which we are all liable. Indeed, were any charlatan to set up as a specialist in Raynaud's disease he would probably find that we all had it. This view makes clear its wide and many relations; for instance, it explains why it may be associated with erythromelalgia, which is a vaso-motor neurosis in which the vessels dilate instead of contracting, and in which, as I have already mentioned, paralysis of the muscles of the feet has been observed, reminding us of the state of the muscles in our case. It renders the association of Raynaud's disease with urticaria and with local irregular mottlings intelligible, and shows that the girl in Mary ward in whom mottlings came out from time to time in various parts of the body, was really suffering from a variety of Raynaud's disease, and this view also warns us not to necessarily expect to find an organic cause for the disease; we can no more hope always to find an organic explanation for paroxysmal vaso-motor attacks leading to blueness of the fingers, than always to find an organic explanation for paroxysmal epileptic fits. Both conditions rarely kill, and we only get an opportunity of a post-mortem examination in patients who have died of something else.

This way of looking at Raynaud's disease also gives us some clue to its frequent occurrence in women about twenty years old, for the nervous system is particularly unstable in women of this age, and it also helps us to understand why the disease is often met with in hysterical subjects. But wide as this view is, it still leaves us in the dark as to why the condition is symmetrical and why it is paroxysmal.

Treatment.—In the first place, and above everything, keep your patient warm, especially never let the fingers get cold. She must wear warm gloves indoors and out, and use a muff. She must wash as little as possible, and never in cold water. Should she suffer much, she had better always live abroad in some warm place in the winter. Keep her in the best general health possible. Nitrite of Amyl was tried some few years ago without much success, but a case we had in Miriam ward a few weeks ago, and another case I have seen, seem to show that Nitro-glycerine is occasionally beneficial. The patient in Miriam ward always had her attacks worse in the early morning, so when she first woke we gave a tabella of Nitro-glycerine, and gave her one at intervals of an hour for three hours: under this treatment she decidedly improved, but I must add that I have seen it fail. It has been advised to put the hands in tepid water, to place one pole of a mild galvanic current in the water, and the other on some indifferent part of the body. We did this some years ago for a patient, and it certainly relieved the attacks at the time, but it did nothing towards permanently preventing them. Quite recently I have found Methylacetanilide—three grains every two hours given for six hours during an attack—decidedly beneficial in alleviating the pain.

Prognosis.—As is the case with some other diseases, although you will probably be very disappointed in your attempts to benefit the patient, and the case will drag on without any improvement till you feel desperate, yet in most cases, if the patient will carefully avoid cold—the great exciting cause—she will probably, in the course of several years, get less and less liable to the attacks, for it is not common to meet with the disease in old women. The other day I wrote to a patient of mine who, while in the Hospital, did not improve at all; and her father wrote to say she had gradually got quite well. If the attacks are severe, and you fear gangrene, you must be very strict in insisting on warmth.

Postscript by Dr. Hale White.—Since this lecture was given a most interesting paper has been published by Dr. Solis-Cohen (Vaso-motor Ataxy, *American Journal of Medical Sciences*, February, 1894), and his cases strongly support my contention that to understand Raynaud's disease we must take a wide view of it and its very numerous relationships, which for the most part indicate instability of the nervous system. From among many of his cases the two following may be quoted: A woman, aged 18, had an attack of sudden dimness of vision, was very liable to blush, had "burning flashes" in which red patches appeared in various parts of the skin, and also suffered from erythema nodosum and urticaria. Now, although her attacks were those of vaso-motor dilatation, instead of constriction, she had one cousin who had mild Raynaud's disease in the winter, another had chorea, another was said to have exophthalmic goître, another had chilblains, and the family as a whole was neurotic. Another woman, aged 19, had mild epileptic paroxysms, she was also liable to paroxysmal flushing, she had urticaria, palpitation of the heart, and exposure to cold produced dusky blueness of the hands.

Guy's Hospital Rifle Association.

Ilford Rifle Range will be open for practice on May 3rd and 8th, from 2 till 6 p.m., and every member is requested to go down. The Range is ten minutes' walk from Ilford station, to which there are frequent trains from Liverpool Street.

Bisley regulations will be in force, and a good attendance of new members especially is desired, as the formation of the team for the first match will be partly decided by the performances on these two dates.

Any further information can be obtained from the Secretary.

H. FULHAM-TURNER.

Hospital News.

In the Surgical Wards.

Cases under Mr. Davies-Colley.

Lydia.

2. Ectopia Vesicæ. On April 24th Mr. Davies-Colley operated on this patient, aged 3, by cutting at the junction of the skin and mucous membrane of the bladder, so as to free the wall of the bladder on each side from its connections to the skin and subjacent parts. The fore edges of the bladder wall were then brought together by several fine catgut sutures, so that there was a raw surface looking forwards. Over this raw surface the skin on either side, after being dissected off the abdominal wall, could be brought together by means of button sutures. Mr. Colley pointed out the advantages he hoped to attain by these means. In the operation performed by Mr. Wood, the skin flaps, turned with the cutaneous surface towards the bladder, were apt to set up a cystitis as soon as the hair grew; and the alkaline urine would cause severe excoriation of the thighs and parts round the opening of the bladder. At a previous operation on this child about a year ago Trendelenburg's method was tried; through a single median incision behind, the sacro-iliac synchondrosis on either side was divided, and by means of strapping an attempt was made to bring the pubic bones together in front, where the symphysis would be in a normal subject; the edges of the mucous membrane of the bladder were at the same time raised and sutured together. But the operation did not succeed, because the skin would not stand the pressure of the strapping, and the sutures in the bladder gave way. It is hoped this time that by raising the shoulders above the hips, the urine may be got to run downwards away from the sutures. But the difficulty of preventing urine from getting in between the raw surfaces of the skin flaps and mucous membrane flaps, and setting up inflammatory softening, allowing the sutures to cut out, will, Mr. Colley thinks, perhaps be too great. In that case he would operate in the same way some years later with a better chance of success.

3. Psoas Abscess. On April 13th an incision was made parallel to and just above the outer part of Poupart's ligament, and the abscess evacuated. A long scoop was then used to scrape from the walls of the cavity the tuberculous granulation tissue. A sponge on a long holder was used to clean away the débris, and the cavity irrigated with perchloride solution, and glycerine emulsion finally introduced. The wound was then stitched up, a tube being left in for one day and then removed without removing the inner layers of the dressing. It was dressed after a week; primary union had taken place. Mr. Colley pointed out the advantages of the incision he employed. The lumbar incision theoretically gave better drainage, and certainly was easier to keep aseptic. But he found that after the abscess cavity was represented in the loin only by a sinuous track, and was by no means easy to empty in that situation; and in any case the wall of a cavity reaching down into the thigh, as this one did, could not be thoroughly scraped without a lumbar incision. It was an immense advantage to be able to get the wound in these cases to close by primary union, and avoid the dangers of a discharging sinus in the groin.

Luke.

6. Radical cure for hernia: the neck of the sac was exposed and divided. A needle piercing the abdominal wall between the internal ring and the anterior superior spine, guided by a finger introduced through the neck of the sac into the peritoneal cavity, was brought out through the neck of the sac, threaded with catgut, and withdrawn. Introduced similarly at a point about an inch higher, the needle was threaded with the other end of the same piece of gut and again withdrawn. A loop was thus made by which the neck of the sac could be drawn up into the abdomen and doubled upon itself. The external ring was closed with silkworm gut, and the wound sutured.

7. Hydrocele injected 16 years ago, and cured for 13 years. Since then it has been tapped from time to time. The sac was laid open, and the parietal layer of the tunica vaginalis removed. The wall was quite thin, and there were only slight traces of adhesion between the two layers.

14. Cold abscess in thigh opened and scraped. Wound healed by primary union at first dressing.

21. Excision of semi-membranosus bursa. On exposing the interval between the gastro-enemius and semi-membranosus a swelling three-quarters of an inch in diameter was found. Dissection between the muscles showed that its walls gave origin to some of the fibres of the semi-membranosus, probably the aponeurotic expansion over the popliteus. There was no neck to the sac, it was cut away, no stitches being inserted into the sac.

Cases under Mr. Lucas.

Job.

R. F., æt. 3. Admitted for sinuses in perinæum and inner side of thigh; was under Mr. Lucas in April last, when he had an abscess opened which extended to tuber ischii, round the psoas tendon, and towards capsule of hip-joint. The sinus never healed, and lately an abscess in his perinæum burst. The sinus in his perinæum extends to the root of the penis; that on inner side of thigh to hip-joint; no signs of hip disease; no stricture. Under an anæsthetic, the two sinuses were found to communicate with a cavity between the adductors, in which was a sequestrum, probably from the ascending ramus. This was removed and the wound stuffed.

J. B., æt. 77. Admitted for swelling of left testicle. Patient had syphilis fifty years ago. He noticed enlarge-

ment for first time last Christmas, which has increased to the size of an orange. The swelling, evidently orchitic, is hard, heavy and smooth; skin not adherent, but shows enlarged veins; no testicular sensation; no fluctuating spot; no hydrocele; painless; thickened cord; lump in iliac fossa, ? gland or fæces. *Diagnosis.*—Sarcoma of testis. *Treatment.*—Castration.

Lydia.

M. O., æt. 23. Admitted for swelling on front of right clavicle. No history of tubercle. Patient noticed this swelling five years ago when it was the size of an almond; it has steadily grown to its present size, that of a hen's egg. It is situated just beneath the middle of clavicle; freely movable; skin non-adherent, painless, hard, tense and elastic; non-fluctuating; no axillary glands; unattached to clavicle.

Diagnosis uncertain. It proved to be, on dissecting it out, a gland which, on section, showed a number of firm yellow caseating patches, probably tubercular.

Mrs. R., æt. 46. Admitted for tumour in left breast. Patient has noticed transitory swellings in the same breast before; had no children. Present swelling noticed last Christmas, is growing rapidly and more painful. The swelling, which is in the upper part of the left breast, is the size of an orange, freely movable, globular, hard, but not stony, smooth and painful, skin shows slight dimpling over one spot where fluctuation is evident, slight enlargement of axillary glands. Nipples small and ill developed, same on both sides. *Diagnosis.*—Cystic sarcoma.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Philip.

21. Patient has had ague and other fevers in India several times, but not dysentery. He is pale, wasted and sallow; has an ague-cake spleen and an enlarged liver. Much ascites, and on admission anasarca. Aortic and mitral regurgitation. He has been a considerable beer-drinker, and has an habitual rise of temperature every evening.

25. Alcohol, jaundice, enlarged liver and spleen; probable cirrhosis. This patient also has an evening rise of temperature.

Mary.

30. Hodgkin's disease. Slight enlargement of glands in neck, axillæ, and groins since childhood. Enormous hypertrophy of glands in submaxillary region since last August. Liver and spleen not enlarged. Evening temperature of late 105. No pain or disturbance of any sort to account for it. Patient has been taking as much as ♏ xiv. of liquor arsenicalis t.d.s., but it has had to be discontinued for the present.

Those interested in cardiac cases will find a series worthy of study in the following:—Philip 21, 22, 23, 24, 28, 36, 39, and Mary 27, 31.

Cases under Dr. Goodhart.

Philip.

8. J. R., æt. 34. Taken ill two days before admission with rigors and vomiting; temperature 101. Pain in right hypochondrium; loud rub all over right base; faint bronchial breathing just outside right nipple; heart rapid, and sounds "tumbling" at base. Respiration, 40; pulse, 160. Face bloated, and slightly icteric tinge; skin hot and dry; liver large. History of alcoholism. Lobar pneumonia; pleurisy. ? Pericarditis.

15. S. B., æt. 20. Admitted for dyspnœa; history of rheumatism; loud mitral systolic; very rapid and irregular heart, fluid at both bases; cardiac diffuse, best marked 1½ inch outside nipple line in 5th space. Intermittent pyrexia, reaching 130; respiration average 50. Present illness about three weeks; improved by strychnine and digitalis; but there has been persistent retention of urine, which seems to be due to localised peritonitis about the liver; a loud rub being heard over the lower border of liver, which reaches about two inches below ribs; *i.e.*, patient is unwilling to use diaphragm or abdominal muscles for fear of aggravating pain. Aspect suggests recent pericarditis. ? Malignant endocarditis.

1. J. E., æt. 64. Pulsating tumour in 2nd right space; no bruit; unequal radial pulses; heart sounds characteristically soft and distant; red blush all over front of chest; aneurysm of aorta.

Mary.

Cot 54. R. E., æt. 3. Sore throat two days before admission. Tracheotomy for urgent dyspnœa; membrane on fauces abundant. Since then has done well, *i.e.*, since April 17th; tube left out altogether on April 24th. Fluids began to come through tracheotomy wound on April 24th, when child attempted to swallow; therefore fed on semi-solids; medicine and some milk being given by nasal tube. Albuminuria first noticed on April 23rd, ·05 per cent.

Cases under Dr. Hale White.

Mary.

2. L. M., æt. 23. Admitted on March 22nd with a week's history of abdominal pain and sickness. She has had rheumatic fever. Has an abdominal expression with dark rings under eyes; soft rapid pulse, 104; temperature, 101·2; great abdominal pain. The abdomen was rigid, uniformly distended and tender, not moving with respiration. There is an aortic too and fro murmur. Peritonitis was diagnosed, although no definite cause of the same could be discovered. She was treated by milk diet, abdominal hot fomentations, and large doses of opium, and on March 27th the temperature became normal, the abdomen became relaxed, and moved freely with respiration, and she looked and felt much better. On March 30th, the temperature began to rise, and remained up. On April 1st an enema was given, as it was thought possible that the constipation was the

cause of the pyrexia. The enema acted, but the temperature remained up, and on April 2nd patient complained of pain in the left side. As the pain was felt well above the margin of the ribs, and as there was a slightly impaired note on that side, which did not move so well as the other, pleurisy was diagnosed. On April 3rd a rub was heard, and well-marked signs of pleuritic effusion soon followed. As the temperature still kept up, on April 12th a needle was put in, and clear serum drawn off. Patient's general condition was meanwhile getting gradually worse. On April 16th she vomited during the early morning, pulse became rapid, 135; patient complained of sore throat. Dr. Hale White saw her on this day and discovered a tender spot above, and to the left of the umbilicus, where there was also an increased sense of resistance as compared with the opposite side; it was thought to be due to suppuration shut off from the general abdominal cavity by adhesions. There was tenderness also in the splenic region, where there was also an increased sense of resistance. Dr. Hale White thought there was some deep seated suppuration beneath the left side of the diaphragm and limited by adhesions. Operation was advised, but absolutely refused by the patient and her friends. On the night of April 16th, patient had a rigor, the temperature rising to 106. On April 17th, pulse, 160; patient collapsed and sweating; she was again advised to undergo an operation but refused, and by this time she was so bad, that Mr. Dunn thought there would be little prospect of success. The chest was aspirated, and about twenty-one ounces of blood-stained pus drawn off; the pus had a fæcal odour. Since that time, after a very temporary improvement, patient gradually sank. Before death, optic neuritis was observed, and patient complained of pain over the liver. She died at 7.30 a.m. on April 20th. At various times, the following points, amongst others, were taught.

On admission.—The diagnosis was first discussed, and it was pointed out that the condition of the abdomen, aspect, pulse, temperature and history, rendered the diagnosis of general peritonitis easy. It was then considered to be non-suppurative, for if the patient had been ill so long, that suppurative peritonitis would have made her much worse than she was; it was too acute for tubercular; there was no suspicion of growth, and no evidence that it was associated with Bright's disease, or had spread from typhlitis, and there is no such thing as rheumatic peritonitis. Under these circumstances the most likely source was the genital organs (often associated with gonorrhœa and met with in prostitutes), but in this patient the hymen was unruptured. The subsequent improvement and fall of temperature to normal, and the adhesions found in the abdomen confirmed this diagnosis of simple non-suppurative peritonitis, and it was pointed out that often in peritonitis it is impossible at the bedside to assign a cause. Patients with peritonitis, like those with diabetes, can bear enormous doses of opium. In peritonitis keep watch on the pupils, for the shallow breathing of the disease makes respiration sometimes a fallacious guide, which, if followed, may lead to the opium being diminished too soon. Prognosis was considered good from the pulse, slightness of vomiting, expression, temperature neither too high nor too low. The improvement and fall of temperature and return of abdominal movement bore out this prognosis. Later on this case reminded us that pleurisy may follow peritonitis, but peritonitis rarely follows pleurisy. After it had been diagnosed that there was suppuration near the umbilicus and also near the spleen in each case, limited by adhesions of the previous peritonitis (this loculated suppuration after peritonitis is known, but fortunately rare), the rigor and sweating were regarded as pyæmic, but it was suggested that as the patient had chronic endocarditis, that she was suffering from malignant endocarditis, but Dr. Hale White rejected this view, because the cardiac condition was absolutely unchanged during her stay in the Hospital (and she certainly had not malignant endocarditis on admission); there was no evidence of emboli anywhere (it was suggested that the splenic tenderness was due to an embolus there, but this view would not explain the pleurisy, nor the fullness, nor the umbilical tenderness), and the temperature was unlike malignant endocarditis. It was, however, pointed out that if she survived the pyæmia long, very likely malignant endocarditis would supervene and also multiple small hepatic abscesses from partial pyæmia in connection with the splenic abscess. The optic neuritis was regarded as pyæmic. The pus that was drawn off from the chest had a fæcal odour which pointed to thinning of the diaphragm, allowing diffusion of gas from the intestines; it by no means indicated actual perforation of the bowels.

At the post-mortem there was found:—Collapse of the left lung, due to empyema; some thickening of the aortic valves; an abscess beneath the diaphragm between the stomach, spleen and pancreas, this had just perforated the thinned diaphragm, and at the post-mortem was in communication with the pus in the pleural cavity. An abscess in front of the stomach, just above and to left of the umbilicus, which was on the point of perforating the anterior wall of the stomach. On a corresponding situation on the posterior wall was an ulcer, probably due to contact. There were numerous peritoneal adhesions. No evidence of malignant endocarditis.

6, and Cot. Two cases of enterica. *Value of eruption in diagnosis.*—Dr. Hale White explained that by far the most distinguishing characteristic of the spots is their appearance in successive crops, each crop lasting two or three days, and then disappearing, to be followed by another. The abundance of the spots is no criterion as to the severity of the disease. They may be very abundant in a mild case, or very scanty in a severe one (similarly with intestinal ulceration). The characteristic rash is present in 75 per cent. of all cases of enterica. Their most common situation is on the abdomen; they may appear

on the chest, back, arms, or even on the face. Of the early symptoms of enterica constant headache, with pyrexia, is the most valuable in diagnosis. The headache is often severe, and may extend to the back of the neck. In the case of the child in cot, the diagnosis rested for some days between *meningitis* and *enterica*, and the latter was diagnosed after some days owing to the absence of further signs of meningitis and the appearance of the motions. The diagnosis is often a difficulty, especially as some cases of enterica are accompanied by deafness, otorrhœa, or even optic neuritis; the latter is not so severe as in meningitis or lateral sinus pyæmia, when there are often indications of suppuration in the form of rigors, etc. *Sponging* for hyperpyrexia is very beneficent and pleasant for the patient. The presence of bronchitis is no contra-indication for this treatment—in fact, the only conditions in which sponging is harmless are perforation and hæmorrhage; in patients with delirium the effect is often most striking. *Diarrhœa* seldom needs treatment. If it is severe, the motions should always be examined for clots of undigested milk, and, if present, giving the milk peptonised usually cures the diarrhœa. It is very rare for the administration of astringents to be necessary. *Constipation* is present in many cases, and may need treatment. If patient complains of discomfort, it will probably be necessary to prescribe an olive oil enema. Bronchitis is often present with enterica, and leads to the enterica being overlooked.

STEPHEN.

27. Æt. 45. Right hemiplegia came on gradually three or four months ago; aphasia came on two weeks ago. Specific history. Dr. Hale White emphasized the fact that movements rather than muscles were represented on the cortex—that in the case of movements habitually performed unilaterally, *e.g.*, those of the hand, the cortex of the opposite side governed them chiefly, and the cortex of the same side very slightly. Associated movements, however, are more nearly equally represented on the two hemispheres. The consideration of these facts explained the at first sight peculiar effects of hemiplegia, as illustrated by this case. Thus the upper part of the face is much less affected than the lower, the hand more than the elbow, the elbow more than the shoulder, and when we come to the perfectly associated movements of the trunk, there is very little to be noticed at all. Diagnosis between cerebral hæmorrhage and thrombosis. *Age of Patient.*—In the old, hæmorrhage, other things being equal, is more probable; *vice versa* in the young. Pulse, high tension: hæmorrhage more likely. Pulse, low tension: thrombosis more likely. If a specific history, thrombosis, due to syphilitic endarteritis, is probable. If a history of Bright's disease, hæmorrhage probable. Attack sudden, points to hæmorrhage. Attack gradual, points to thrombosis. In this case there was a specific history. Patient was middle-aged and the attack was gradual; hence thrombosis, due to syphilitic endarteritis was diagnosed.

A Case of Myxœdema, with Epileptiform Attacks.

J. S., æt. 50, weaver. Nothing important in family history. Patient had rheumatic fever about thirty years ago; otherwise has been very healthy; is married, and has healthy grown-up children; has always been steady and temperate.

Nearly three years ago when returning from work with some other men, felt suddenly giddy and dropped on his hands and knees, no vomiting nor loss of consciousness, before he could be helped he got up and walked on, since then has been subject to frequent attacks of vertigo accompanied sometimes by vomiting, sometimes violent diarrhœa, almost always by "clammy sweats," never by loss of consciousness; he always sits down to avoid falling; no paralysis nor affection of speech or memory has been noticed to follow these attacks. On a few occasions there have been "seizures" during sleep, which the relatives say are ushered in by loud groaning, the muscles then become rigid, the face cyanosed, the eyes are rolled upwards and fixed; sometimes convulsed movements follow. Patient always wakes up after the attack very much dazed. These epileptiform attacks have never occurred except during sleep. Patient has not felt warm for at least two years. Two years ago had influenza; had always been a very thin man, but after this illness "went to a shadow." He was supposed to be in a rapid consumption, and has done no work since then till last week. About a year ago patient began to increase very rapidly in size, so that whereas in health he used to weigh about 10 stone, his weight rose, in a few months, to 13 stone 4 lbs. As the weight increased lassitude became more marked, till the slightest exertion caused breathlessness and cold sweats, with a feeling of great distress.

Condition when first seen, January 29th. Very marked "solid œdema" exists everywhere except apparently under the scalp; the hair is said to be much thinner than two years ago. A little pitting can be produced by firm pressure over the tibæ. There is a deep sharp groove where a piece of tape is tied tightly round each leg to serve for a garter. The expression of the face has been, I understand, very much altered by the disease.

Urine, acid, 1018, pale, no deposit; albumin irregular in quantity, said to be unaltered by present illness. Respiratory system: chronic cough, otherwise normal. Circulatory: pulse 74, heart sounds normal (sphygnograph now shows anachrotic tracing, whether due to disease or thyroid extract, as it was not taken till he had been some weeks on thyroid, I do not know). Nervous system: memory and mental condition generally clear, speech normal, sight, hearing, and sensation unaffected. Optic discs normal, pupils react to light and accommodation, knee-jerks equal and moderate, no ankle

clonus, abdominal, cremasteric and plantar reflexes present. Temperature 97 in the mouth.

There is no enlargement of thyroid and no palpitation —eyes not prominent.

I have not seen fits noticed in connection with myxœdema, but Fagge says they occurred in monkeys on which Roche performed thyroidectomy. Gowers says myxœdema occurs in association with exophthalmic goître, and large thyroids are common here. Sporadic cretinism still occurs here, though not so frequently as formerly. On thyroid extract patient has improved remarkably, all fits have ceased, the weight has diminished one pound per week, his appearance is rapidly altering, and he can do a little work now. The sensation of cold is going, though the temperature is still subnormal.

S. W. MacILWAINE.

Henry Cline's Lectures, A.D. 1789.

By Thomas Bryant, F.R.C.S. Eng. and I., M.Ch.

Henry Cline's Lectures on Anatomy, delivered at the United Hospital Schools in 1789, included Anatomy, Physiology, and Pathology; the Operations of Surgery, with the Methods of Applying Bandages. From MS. notes of these lectures the following extracts may be read with interest.

Suture of Tendon.

Cline records case of man who was brought to the hospital with division of the *posterior tibial artery* and the *tendo Achillis*. The hæmorrhage yielded to compress, but the tendon was properly brought together by sutures, and the man recovered with good limb.

Nutrient Enemata.

Cline recommended the use of *nutrient enemata*, and quotes a case of wounded intestine which under their use for three weeks made a good recovery.

Sacculi in Bladder.

We, said Cline, sometimes have a projection outwards of the bladder which does not produce mischief except *a stone is in it. This circumstance gave merit to* Mrs. Stevens' medicine, as the test was made on a patient who when examined was known to have a stone in the bladder. After taking the medicine for some time, upon examination no stone could be found, when it was thought that the Lixivium had been an actual solvent, for which she (Mrs. Stevens) received £5,000 from Parliament. After the death of the patient the stone was found lodged in a sacculus, and so evaded the search.

Suprapubic Lithotomy, &c.

"The last operation (1789) of this kind was performed by Dr. Thomson, of the London Dispensary, which succeeded.

"It is recommended to puncture here in a retention of urine, to which there is this inconvenience—the water continuing to pass by the orifices not corresponding in the abdomen and exciting inflammation. A canula has been proposed to be introduced and kept in, which is liable to ulcerate through, and produce great mischief; hence it must be a very hazardous operation. From this it has been proposed to puncture the bladder at the posterior part through the rectum by a curved trocar, which is dangerous from wounding the peritoneum; if the puncture is made close to the prostate gland the vas deferens may be wounded.

"Mr. Cline proposes to make an incision in perineo as for the stone, and then pressing the bulb on one side, cut into the bladder on one side of the prostate gland, which is thrust forward. In this mode the operation is not difficult, and you have a free passage for the water."

Nephrotomy.

"*With stone in the kidney, ulceration sometimes takes* place from inflammation of the pelvis, and matter has been known to dissect through the psoas muscle. A calculus was extracted by that means. Nephrotomy is described; but it is impossible to perform it without such an abscess, from the danger of wounding the vessels; but when inflammation takes place under the adipose membrane, it may probably be removed, but not by any other mode."

Tooth Grafting.

"Mr. Cline has the head of a cock (in preparation now at St. Thomas's Hospital), where the spur was taken from the leg and placed in the comb, to which it adhered perfectly, and grew with no other difference than being somewhat softer.

"Mr. Hunter took the testicle from a cock and placed it in a hen, which united perfectly. This mode of *tooth grafting* has produced inflammation, exciting the most exquisite pain; infection may be incurred of the *venereal virus*, which has deterred many from prosecuting it."

From the Gazette's Special Pathologist.

O., Coventry.—No bacilli present.

F. K. H., Hampstead.—No bacilli were found in either specimen.

G. F. H., Balham.—No bacilli present.

M. B., Swansea.—No bacilli present.

M., Kidderminster.—The kidney is granular. It shows parenchymatous and interstitial nephritis.

Sputa and other specimens for examination should be forwarded as soon as procured.

A few lines of clinical history are of great value, especially when morbid organs are sent.

PATHOLOGIST.

Specimens for examination and description in this column should be addressed to H. Hunt, Gazette, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

Passim.

It is vacation; and it is a time of inactivity in sport, when goal-posts are down, and wickets scarcely up; therefore, it is the Big Gooseberry season for the Gazette. We are mostly cheered at this season by the advent of a new Guy's poet; but, so far, he has not shown up; yet the mild winter and the early spring should have brought him along. Perhaps the awful prose of the conjoint scheme and the five years' curriculum is killing all the poetry in our fibre; but we hope not.

It is a nice point in ethics to decide what should be done with the donations in hard cash which turn up in the editor's box. We often unlock it in the fond hope that the New Poet has arrived, and that his burning stanzas will be found within. Instead of these we find threepence in bronze. Now, the precise amount of these contributions would suggest that unwitting patients mistake us for the Samaritan Fund; but on the other hand we hesitate to give up the spoil, because after all we may have friends who think that a few hours at the seaside would do us good, and improve the tone of the paper. Anyhow, we beg to report that the sum received for the current year is fifteen pence.

In about three months' time the Biennial Dinner will once more bring Guy's men together. We refer to it thus early because we understand that Mr. Durham will in all likelihood be present, so that those who are so keenly regretting their absence from the occasion of March 31st, will, after all, have an opportunity of dining with him. The Biennial will certainly lose nothing by possessing a special feature of this kind; and we hope that the management will see that it is held this year at a place suitable for a large muster.

A lady contributor has gone to the trouble of sending us, in charming caligraphy, what we hoped at first was an original contribution. It turned out, however, to be only an extract from the adventures of our old friend Bob Sawyer, with his friends Ben Allen and Hopkins. Perhaps our correspondent is a very young lady; or, maybe, she imagines that Guy's has now so modern an atmosphere that it is one of those places where Dickens is never read. We can assure her that this is not so, and that many of us prefer him to "the Yellow Book;" but we are a bit tired of the weak-kneed Robert, and, as for Hopkins, his jokes were so feeble (especially the affair of the necklace) that we are glad to remember he hailed from Bart's., and not from Guy's.

We published some time ago a reprint of the old ward-rules which were in force at Guy's in the last century. Mr. Prior has unearthed a set, probably contemporaneous, which regulated things on the other side of St. Thomas's Street, and they will be found in another column. There is a Rabelaisian humour about the phrases of these old time disciplinarians, that makes their codes worthy of being preserved.

We are glad to learn that the arrangements whereby nurses and sisters can, without any trouble or expense, borrow the books they choose from the Students' Club Library, works admirably; and to judge by the number of volumes borrowed, the suggestion (which, by-the-bye, was first made in these columns and was immediately acted upon by the Club Committee) has "met a long-felt want." The printed catalogue of the library is in the printer's hands, and will in a few days be obtainable from the Librarian for the modest sum of threepence.

Mr. Dunn has felt obliged to resign the secretaryship of the Physical Society, owing to the pressure of other duties. His resignation was accepted by the Presidents with the greatest regret.

The General Meeting of the Students' Club (with Mr. Durham in the chair) will be held in the Anatomical Theatre, on Thursday afternoon, May 3rd, at 4 o'clock.

The mounted horns which W. G. Rogers —who has been much missed since his recent departure for the Cape—presented to the Club, took up their position on the Smoking Room walls a few weeks ago, and have been much admired. Are there no other old Guy's men who would like at once to perpetuate their names and decorate our rather bare walls? A few gifts of pictures or engravings, armour, or ancient weapons, or big game heads, would be very welcome.

We are very glad to hear that there is likely to be some acceleration of the service in the Club Dining Hall. Arrangements have been made to double the size of the "hot plate," and one of the chief sources of delay (insufficient accommodation) will thus disappear.

There are two men and a boy and a new (and vigorous) horse at work on our ground, and, aided by this happy advent of rain, they are doing great things; indeed, the ground will be in infinitely better condition this year than last.

Mr. G. F. Still, M.A., M.B., B.C., is to be heartily congratulated on obtaining the Murchison Prize. It is the first time that it has come to Guy's. Mr. Still is bent on accumulating honours. It is, perhaps, not generally known that he obtained (*inter alia*) the first place in the Cambridge Final M.B.

Pass List.

University of Cambridge.

EXAMINATION FOR DIPLOMA IN PUBLIC HEALTH,

April, 1894.

Hodgson, V. J. Manby, E. P.

University of Durham.

FIRST EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE,

April, 1894.

Botany with Medical Botany.

Foster, J. J.

SECOND EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE,

April, 1894.

Second Class Honours.

Rygate, A. M.

Pass List.

Foster, J. J.

2nd Conjoint Examination, April, 1894.

Under Old Regulations.

Anatomy and Physiology.

Anderson, C. T.	Mayston, R. W.
Cleveland, A. J.	Pritchard, W. C.
East, W. N.	Rowlands, R. P.
Fitz-Hugh, R. T.	Smith, H. V.
Goldie, F. W.	Smith, W. H. M.
Hodgson, C. R.	Spriggs, E. Ivens
Lavers, N.	Starling, H. J.

Anatomy only.

Clowes, E. F.	Milson, E. H.
Crosby, A. E. B.	Smith, D. L.
Hort, E. C.	Waymark, W. E.

Physiology only.

Peile, H. D.

Under Regulations dated January 1st, 1892.

Anatomy and Physiology.

Batchelor, F. S.	O'Meara, E. J.
Clapham, S. C.	Thornely, M. H.
Evans, Evan	Weekes, C. P.

A Case of Malingering.

The following brief notes of a case under Dr. Hale White may be of interest as showing to what lengths this class of people will go to deceive their friends, and even—with scant success, however—their medical man.

The patient, N. S., æt. 20, a hysterical and neurotic girl, was admitted into Mary 7, on April 20th, with a rash on face, right arm and leg. She is left-handed. Patient seems to have led a happy life, and has nothing *to complain of in her last situation as a seamstress*, nor of her home. Her father and mother are poor Germans. Patient has led a fairly healthy life until the last seven weeks. She was in Patience ward from March 15th to April 14th, with erysipelas of the right arm and chest. She was discharged cured on April 14th. The only noticeable thing about her conduct was that she retained her urine for prolonged intervals—sometimes as long as thirty-six hours—and the difficulty with which her bowels were opened. She went to Dr. Pitt's out-patients' on the 16th with regard to her urinary trouble. Patient was seen about the Hospital on the 15th with her face bandaged up.

On admission into Mary, the skin of the face, right upper arm and forearm, right thigh and ankle were seen to be (in patches) in an erythematous, vesicular or scaly state. Its distribution and various conditions made it improbable that the affection was due to disease, the whole appearance suggesting the results due to the application of some acid or like irritant. Dr. Perry, who saw patient in the surgery, thought this actually was the case. A suspicious circumstance aroused some attention with regard to patient's behaviour. Up to Saturday night (20th–21st) patient passed of urine ʒ44. No more urine was passed until Monday morning, and then only ʒ3. The question arose, was this "hysterical anuria?" When questioned towards the end of her stay in Mary, patient admitted that she could retain her urine at will! Since then it was passed regularly every day.

Boracic ointment was applied, and the patient put on milk diet only. The interest of the case lies in the history given by the girl herself.

This is her story. After her discharge from the Hospital on April 14th (Saturday) patient went home. She admitted coming up to the Hospital on 15th (Sunday), but said she came with a girl friend *to visit a patient in Philip*. She declared that nothing had been applied to her face, arm or leg, neither by herself nor by her friends. On Tuesday (17th) she woke up with her face blistered and red; on Wednesday her arm was bad, and on Thursday her leg. She was admitted on Friday. Patient could apparently give no reason for her condition, and no amount of questioning could shake her declaration. Determined to sift the matter to the bottom, I visited her mother, with a view to gaining some corroborative testimony. Here I learnt that patient had *never* been home since her first admission into Patience, that her father had actually seen her at the Hospital the day after her discharge, and her friends were quite under the impression that patient had been under treatment at the Hospital all the time from the 14th to the 20th. Thinking, perhaps, there may have been some mistake about the day of discharge—which I had only learnt from the patient herself then—enquiries in Patience made the question beyond a doubt that her discharge did take place on the 14th.

The morning after the mother had been seen the patient was cautiously and kindly "re-examined." She at first stuck to her original story, but on being told that I had interviewed her mother and knew more about her movements than she thought, the patient became maudlin, and confessed to having spent the six days *away* from home, with a friend living in the Kingsland Road. To deceive her relatives, she had taken the precaution to meet her father in the colonnade on Sunday—visiting day—thus successfully giving them the idea that she was still under treatment.

The patient, after a good deal of cross-questioning, said that at her *friend's* advice she had, to "soften a swelling in her face," applied to it with a rag a mixture of vinegar and mustard! On its being pointed out that surely her arm, leg and forehead had not needed such severe (softening) treatment, patient admitted, with much contrition (such is the habit of these people) that she herself had applied the mixture, at no one's suggestion but her own!

Why the patient should not have returned to a happy home—as she herself confessed—after her discharge on 14th, is a point which only her friend (a girl much older than herself) can clear up. The patient said she had wanted to enjoy herself in the Kingsland Road. Whatever she may have been influenced to do during these days, and why she should have attempted to disfigure herself for life, are subtle points which require the Watsonian ingenuity of a Sherlock Holmes to elucidate. They are certainly too deep for the ordinary mortal. As Dr. Hale White remarked at the bedside, "the doings of this class of people are perfectly objectless to the sane!" The patient has now almost recovered, and has expressed her regrets "as true as she lay in her bed" (her favourite form of oath) for what has occurred, but she does not know her mother is to fetch her home this time.

H. J. S.

Recent Additions to the Hospital Library.

Presentations.

By the Society. Transactions of the Hunterian Society, Session 1892-93.

Catalogue of St. Bartholomew's Hospital and College Library. St. Bart's Hospital.

Whiffs from the Smoking-room.

The gentleman with *Pick-Me-Up* moved his chair discontentedly, for they were talking shop in the corner. But after all they were only discussing their ideal physician.

The Toynbee Hall Man was for the Physician as an Artist. "After all, he said, "medicine is three or four generations away from being a science, and the greatest among us is he who cultivates his own finer perceptions, he who developes the artist within him——"

"Until, having attained to a sublime personal grasp of the Condition of Things which obtains in the pathological universe, he joins the shades, taking his impalpable knowledge with him, and leaves to posterity nothing but a name." The second speaker was one whose finger-nails are habitually so stained with reagents that the aseptic surgeon will never allow him within the ropes. "If we are all to be artists," he went on, "who is to keep the scientific ball rolling? Those three or four generations you speak of will find us still with no further aids to our 'finer perceptions' than the bit of tube in our ear or the bit of looking glass at our eye. Observation teaches little without experiment. Surely pathology is not to stop short at morbid anatomy, nor is clinical medicine to remain content with the crude aid of the stethoscope, the ophthalmoscope, and the aspirating needle!"

"Let us leave mere experiments to the physiologist," urged the Toynbee Hall Man.

"Ah! the old story," replied he of the stains—"the 'mere chemist,' the 'mere physiologist,' the 'mere pathologist,' or, from the other point of view—the 'mere physician!' I am for the catholic man who works at the linkages. I know the kind our East End Apostle worships—it is he who writes books full of epigram and non-committal statements, containing nothing for the really hungry student to devour;—he whose clinical teaching is indeed made up of artistic qualifyings. The trick is easily acquired, and serves to cloak a real empiricism."

"Not so," retorted the Toynbee Hall Man, "the true empiric is he who writes you up the fifteen points of diagnosis (mostly made in Germany!) for any disease under notice, and then leaves you to wallow in exceptions."

"Well," put in the Literary Man, airily, "life, you know, is made up of learning exceptions; general principles never wear well. Time was when we believed all women to be angels, but how interesting is that life-long study of the exceptions!"

"Pray be less irrelevant," said the Editor, severely. "There is, of course, no science of Woman. Even gynæcology——"

"It is only the fool," interrupted our Medallist, "who does not profit by that definite teaching which the Apostle complains of. A fact is a fact, and, if you can't get it into perspective, that is your fault."

"Just so," said the Tonybee Hall Man, "but it takes the artist to put facts into perspective. Your teacher from the laboratory is Japanese in his methods. He has an appalling flatness of field."

"With accuracy of detail," replied our Medallist. "Confound your Impressionists! If they are a nuisance in Art, they are worse still in Medicine. After all, the Jap is the true artist; his work is science and art combined. A Japanese drawing always reminds me of a well-written scientific paper; the actual facts are all there, and yet one does not miss the æsthetic appeal."

"Pray keep to the point," said the Editor, "or I shall never get all this wisdom into a 'whiff,' and that would be a pity."

"The laboratory worker is the most unselfish, anyhow," said the Colonial, "save, indeed, when his laboratory is a mere advertisement. Your artist-physician affects to despise the laboratory, simply because he has never troubled to face its frequent failures and rare rewards; cultivating one's Personality pays so much better."

"On the other hand," remarked the Scholar, "your laboratory man is often painfully deficient in personality, which, after all, is an important matter for those whose final material is humanity. We cannot yet affect to despise culture and all that springs therefrom. We must yet find Suitable Quotations to head our Chapters! Now some of your *fin de siècle* Consultants have no more scholarship than——than——"

"The Guy's Gazette," suggested somebody, but the Editor looked unconscious.

"Well," said the typical Guy's man, who till now had remained silent, "let it be ours to steer the middle course—the Artist in the Laboratory is a pretty picture!"

"Yes," said the Litterateur, as the assemblage broke up, "ours must be the eclectic position. Other people, as usual, are but awful warnings."

When they were gone, the *Pick-Me-Up* reader waved his paper violently. He was striving to clear the atmosphere somewhat. 'O.

Amateur Theatricals at Streatham.

On the evenings of the 9th, 10th, and 11th instant, under most distinguished patronage, and before a highly appreciative audience, an original two-act comic opera, entitled "The Buccaneers," was performed at the Town Hall, Streatham, in aid of a local charity.

This is of interest to us as Guy's men, inasmuch as one of our number composed, or, rather, aided in the composition of the music, while several others took prominent parts. We refer to Mr. B. F. Pendred in the first instance, and to Messrs. V. Pendred, H. J. Spon and J. E. Coulson in the second instance.

The author of the libretto was Mr. L. St. L. Pendred, the music being composed by Miss Glazier and Mr. B. F. Pendred.

After the, on the whole, favourable notices published in some of the daily and weekly papers—notably the *Daily Graphic*, *Referee*, *Era*, *Stage*, and the local journal—we will confine our remarks to giving a short sketch of the play, and not indulge in much criticism, feeling our inability to do so with justice, both to the play itself, and the music, and to its exponents. The plot is very much as follows :—

A certain Don Pedro, captain of a band of ruffianly buccaneers who have foresworn matrimony, falls in love with Nita, a maiden of Cadiz. He feels himself in rather an awkward situation, as by a law which he and his crew have sworn to keep, death by walking the plank is the penalty for any member of the band who should transgress this law.

The play commences on the return of the buccaneers from a cruise, the scene being laid in a street in Cadiz. The curtain rises to a blood-curdling song and chorus, sung by Ruy Gomez, the first officer, and the crew. The latter then adjourn to a neighbouring inn for a carouse, leaving the first officer with Gregorio, chaplain to the band, also a creature of Gomez.

At this point Nita comes on the scene, and questions Ruy Gomez as to whether he knows aught concerning one Don Pedro. She is joined by her friend, Marietta. Gomez does a judicious piece of lying, and arranges a meeting between the lovers at nightfall; meaning, with Gregorio's help, to personate his captain and run off with Nita and her companion. In this he almost succeeds, and is only stopped by Don Pedro, who happens to pass at the time; the crew rush up to the spot, brought by the cries of Nita, her friend Marietta, and some other lady friends. Ruy Gomez sees his opportunity, and accuses Don Pedro of breaking the law *re* matrimony. The latter openly avows his love, is arrested, committed for trial, and taken on board. Don Pedro has, unfortunately, made an enemy of one Blotti, a letter writer, whom he maltreats. Blotti is at his wits' end to know what to do for a livelihood, owing to the misogynetic tendency of the male population of Cadiz, and the consequent impecuniosity of the female "department."

Act II.

The second act consists of the trial scene and the finale. The scene is on board the Buccaneer's vessel. The curtain rises on Blotti, who, sick of his profession, has determined to "Misogynize," so has become a buccaneer. He seems to feel the change a great deal, being rather nervous of various parts of his accoutrements. The day of trial is appointed. The judge is, of course, Gomez; the jury selected from the crew; the witnesses being Gregorio and Blotti.

On the eve of the trial, while Blotti is on guard, the vessel is boarded by Nita, her friend, and a band of impecunious maidens, who have an inkling as to the result of the trial. They terrorize Blotti—who has done an excellent stage-faint on their arrival—and concoct a scheme to save Don Pedro, and then hide about the vessel.

The trial begins. The evidence is most damning. Sentence is passed and is about to be executed, when on rush Nita and her friends. Marietta goes up to Gomez and threatens to inform the crew of his attempted forcible elopement, thus putting him in Pedro's position. Gomez buys her silence by offering to marry her, and the impecunious maidens get comfortably paired off, as in the "Pirates of Penzance."

The caste was as follows :—

Don Pedro	...Mr. Berthon F. Pendred.
Ruy Gomez	...Mr. V. Pendred.
Gregorio (chaplain) ...	...Mr. R. H. W. Hope.
Blotti (public letter writer)	...Mr. H. J. Spon.
Marietta (Nita's friend)	...Miss Alice Givern.
Nita	...Miss Rose Alba.

The burden of the play falls on Nita, Don Pedro, and Ruy Gomez. Nita's singing was good, as was also her acting. Both Don Pedro and his first officer seemed out of voice on the first night, though doubtless, they were in better form on the two successive evenings. Blotti had not much to do. In the first act he might with advantage have had a good deal more. His *pas seul* in the second act was very effective and was encored to the echo. The choruses were undoubtedly the feature of the piece. The dresses of the ladies were very bright and pretty, and were only excelled by their wearers. The music also was bright and the dances exceedingly pretty, notably so a gavotte by the Misses Glazier and a fan dance by all the ladies. The whole opera was well put on, showed excellent stage managing and very careful rehearsing.

Financially, we believe the concert to have been very successful, £150 being realised.

The Call of Duty

AS UNDERSTOOD AT ST. THOMAS'S A CENTURY AGO.

THE DUTY OF THE SISTER.

I. THAT the Sifter keep their Ward conftantly neat and clean; that the Filth and Stools be carried out of the Ward by Six o'Clock in the Morning in Summer, and Seven in Winter, to the appointed Places; and what is fit to be carried out at Night, by Eight o'Clock in Winter, and Nine in Summer.

II. That they be careful there be no playing at Cards, Dice, or any other Games in this Houfe, to give Notice to the Treafurer or Steward, if any offend therein.

III. That they Wafh, or cauſe to be wafhed, all weak Peoples Clouts, without taking Money or Reward for the fame. That they give the Medicines as directed; the Night Medicines by Eight o'Clock in Winter, and Nine in Summer.

IV. That they appoint fome ſober Patient to crave a Bleſſing and return Thanks at every Meal; to read at

the Deſk on *Sunday*, and the *Rules* and *Orders* to be obſerved by the Patients to be read aloud in the Ward every *Friday* Morning.

V. That they are not to receive any Fee or Reward, on or after Admiſſion of any Patient into the Houſe, on pain of Expulſion.

VI. That no Patient be kept in the Houſe after preſented out, or to whom Phyſick or Surgery is not adminiſtered within a Week after Admittance, without leave from the Treaſurer or Steward, on pain of Expulſion.

VII. That they don't permit any Perſon whatever to come into the Wards with any kind of Goods for Sale, or ſuffer any Patients Friend to ſtay in the Wards to Smoak, Eat or Drink, to the hurt of the Patients: And that no Patient be permitted to Drink ſtrong Liquor without the Approbation of the Doctors or Surgeons, under the Penalty of incurring the Diſpleaſure of the Committee.

VIII. That no waſhing of any kind whatever be done in the Ward, but in the Common Waſh-Houſe.

IX. That each Siſter is to make the Beds, and clean that ſide of the Wards on which the Chimneys are.

X. That in Caſe of the Sickneſs or Abſence of the Nurſe, the Siſter of that Ward ſhall apply to the Matron for a proper Perſon to ſupply the Place of ſuch Nurſe.

XI. That every Siſter take Care that ſuch of the Linen of the Houſe, as is paſt Service, be delivered clean to the Matron.

THE DUTY OF THE NURSE.

I. SHE muſt attend the Surgeons during the whole Time of dreſſing the Patients, and give them Aſſiſtance in ſuch Dreſſing, and take away all foul Rowlers, Bolſters, Rags, *&c.*, and furniſh clean.

II. She muſt Stupe as often, and in ſuch manner, all ſuch Patients as the Doctors and Surgeons ſhall direct, and attend the working of all ſuch Clyſters as ſhall be given in her Ward, and alſo attend the working of all the Vomits.

III. She muſt help out of Bed all infirm helpleſs Patients, and make warm the ſame, and help them to Bed again.

IV. She is to dreſs all ſuch Pottage, Water Gruel, or other proper Diet as ſhall be directed for weak and helpleſs Patients.

V. She is to make all the Beds on one ſide of the Ward, and to ſcour and make clean the Beds and Floors of the whole Ward, with the Tables and Forms, the Paſſage and Stairs, and Garrets; to aſſiſt her, ſhe may take ſuch Patients as the Siſter ſhall think fit and able to help her.

VI. She muſt keep clean ſcoured the Cans for Beer, the Broth Pails, Pans, Platter and Plates, *&c.* foul'd at Dinner.

VII. She muſt attend the Butler at the Ringing the Beer-Bell, and take with her ſuch Patients as are able to carry the Beer in ſafety to the Ward, and not ſuffer ſuch Patients to Waſte or Embezzle it by the Way, but ſee that the Cans be carried full into the Ward; and in like manner at his Ringing the Bread-Bell, ſhe muſt attend and take the juſt Number of Loaves for the Patients, who are intitled to it; and alſo at the Ringing of the Cooks-Bell, ſhe muſt attend her, and receive from her the exact Quantity of Proviſions that are appointed for each Patient.

VII. She is to Waſh all the foul Rowlers, Bolſters, Rags, *&c.* that are uſed in the Wards, for which ſhe is Monthly to receive from the Cook, the Quantity of Soap allotted; and ſhe is to take care, that none of the ſaid Rowlers, Bolſters, *&c.* be waſted or deſtroyed through her Neglect.

IX. She muſt clean the Patients and their Bedding, that foul themſelves through Weakneſs or Infirmity.

THE DUTY OF THE WATCH.

I. TO be in the Ward at Seven o'Clock at Night in Winter, and Eight o'Clock in Summer; and to get her Buſineſs done by Ten o'Clock in the Morning in Winter, and by Eleven o'Clock in Summer, that then they retire to Bed.

II. That they ſet to every Patients Bed a clean Chamber-Pot, every Night, and to take Care the Stool be carried to its proper Place, and empty'd by Six o'Clock in the Morning in Summer, and Seven o'Clock in Winter; and what is fit to be carried out at Night, by Eight o'Clock in Winter, and Nine in Summer.

III. To go frequently to the Patients Beds to ſee what Condition they are in, and if any ſeem to have any Alteration for the Worſe in their Illneſs, to acquaint the Siſter therewith.

IV. That they do not go to Sleep, or lye down, and if found ſo to be immediately diſcharged.

THE DUTY OF THE PATIENTS.

I. THAT the Patients, who are able, do conſtantly attend the Worſhip of GOD, in the Chapel, on Sabbath and other Days, on pain of forfeiting One Days Allowance for the firſt Offence, without reaſonable Excuſe; and upon after offending to be puniſhed at Diſcretion of Treaſurer or Steward.

II. That they ſhall not ſwear, revile, or miſcall one another, nor ſtrike nor beat one another, nor ſteal Meat or Drink, Apparel or other Thing one from the other, nor abuſe themſelves by ſtrong or ſpirituous Liquors, nor talk or act immodeſtly, upon pain of Expulſion; and that when they go to or return from their Meals and Beds, they crave GOD's Bleſſing, and return Thanks.

III. That if any Siſter, Nurſe, or Watch, or any other Perſon demand of any Patient, any Sum or Sums of Money, that the Patient ſhall acquaint the Steward therewith, to prevent Impoſition.

IV. That none of the Men go into the Women's Wards, nor the Women into the Men's Wards, on Pain of Expulſion.

V. That no Perſon fetch or carry Fire from one Place to another, ſo as to endanger the Firing the Houſe.

VI. That all able Men and Women do help the Nurſes to clean the Wards, without Money or Reward, on Pain of Expulſion.

VII. That no Patient ſet up in the Wards after Eight o'Clock at Night in Winter, and Nine in Summer.

VIII. That no Patient ſtay out of the Houſe after Five o'Clock at Night in Winter, and Six in Summer, without Leave from the Steward, on Pain of Expulſion.

IX. That foul Patients ſhall not go into any of the clean Wards; and if any ſuch ſhall knowingly or wilfully conceal their having the Foul Diſeaſe, and be placed in a clean Ward, every ſuch Patient, when diſcovered, ſhall be immediately diſcharged the Houſe.

X. The Patients every *Sunday* Morning to put on clean Linen, which they pay the Nurſes for Waſhing, and to have a Pair of clean Sheets every Month.

XI. If any Patients find themſelves neglected, or ill uſed by the Sifter, Nurſe or Watch, that they acquaint the Steward or Matron therewith, that Juſtice may be done them.

XII. Patients that are able, are to attend the Apothecary at his Shop for their Medicines at his Time of ſerving; in caſe of Neglect to forfeit One Day's Diet.

Metropolitan Asylums Board.

MEDICAL INSTRUCTION AT FEVER HOSPITALS.

Notice to Students.

A Course of Instruction in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals, as follows:—

Eastern Hospital, The Grove, Homerton, E. (Dr. E. W. Goodall, Resident Medical Superintendent), on Tuesdays and Fridays, at 10.30 a.m., commencing Tuesday, May 8th, 1894.

Western Hospital, Seagrave Road, Fulham, S.W. (Mr. R. M. Bruce, Resident Medical Superintendent), on Tuesdays and Fridays, at 11 a.m., commencing Tuesday, May 8th, 1894.

South-Western Hospital, Landor Road, Stockwell, S.W. (Dr. F. F. Caiger, Resident Medical Superintendent), on Tuesdays and Fridays, at 11 a.m., commencing Tuesday, May 8th, 1894.

South-Eastern Hospital, Hatfield Street, New Cross, S.E. (near Old Kent Road Station, L. B. & S. C. Railway), (Dr. J. MacCombie, Resident Medical Superintendent), on Tuesdays and Fridays, at 11 a.m., commencing Tuesday, May 8th, 1894.

N.B.—Students desiring to attend a Course of Instruction are required to bring their authority from the Dean of the School to the Clerk of the Metropolitan Asylums Board, Norfolk House, Norfolk Street, Strand, W.C., on any week-day (except Saturday) between the hours of 11 a.m. and 4 p.m.

The fee for the Course of Instruction is £3 3s. for two months, and £1 1s. for each month afterwards; and Students will be required to observe the Rules and Regulations laid down for their guidance by the Local Government Board and the Metropolitan Asylums Board.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Two Guy's Surgeons.

Dear Sir,—In common with, it may be safely said, hundreds of old Guy's men, I read with intense interest and much gratitude the biographical sketches of Hilton and Cock in the Guy's Hospital Reports for 1892. In that of "Teddy" there was no gall, but sweetness only; in that of John Hilton, I felt that this was not the case, and I quite agree with the commentator upon them in the *Medical Magazine*—noticed in your issue of the 24th February last—that the picture of Hilton's (attributed) "brusqueness and stern exterior" has been greatly overpainted. It was my good fortune to be more or less intimately acquainted with him from 1851–6, when I left for a twenty years' continuous service in India. I dressed for him, gained one of his certificates for anatomy at the end of my first year, and, as usual with his dressers, I accompanied him occasionally to assist him in his private operations. During those years I cannot recall a single instance of such alleged "brusque way and rudeness" and "often grossly personal sarcasm" referred to in the able sketch in the Reports. It is quite true that nothing offended him so much as carelessness, inattention or idleness, on the part of students attending either at lectures or in the wards; and that he had a power of rebuke which he did not hesitate to exercise when the occasion arose. But, to me, this appears one of his great gifts and honours. As a teacher, he stood to the students as a master at college, and the application of a corrective and disciplinary régime was equally to his own credit and to the offending student's benefit. He was kind and genial, and a real and devoted friend to those willing to help themselves and so deserve his praise. Moreover, next to Addison, he was in my time the idol of the students generally. The scene of wild enthusiasm which followed his last lecture on anatomy will, I am sure, to those who witnessed and shared it, be as vivid and stimulating now as on the day it occurred. Such a display of admiration, mingled with affectionate respect, surely proves the complete erroneousness of the unfavourable imputations cast upon his disposition.

I need say nothing as to his position as the leading philosophical surgeon of his day, the fascinating character of his lectures and writings, nor the charm of his diagnostic skill, nor as to how he could make the mysteries connected with the sphenoid—the uses and design of each part—the text of an enchaining discourse, and lead the right-minded man into the purest and sublimest regions of a real and rational theology. These, I say, will be known to and acknowledged by all the students of his day: here I am only concerned to mitigate or entirely remove what I feel to be a most unmerited stigma upon his manners and disposition.—

Yours faithfully,
JOHN INCE, M.D.,
Retd. Surgeon H.M.'s Indian Army.

Swanley, Kent.
4th March, 1894.

Dinner to Mr. Durham.

Dear Sir,—In common with many old Guy's men, I deeply regret that, owing to a misapprehension, we were not able to be present at the Dinner given to Mr. Durham, on his retirement from the active Staff at Guy's.

We understood that the Dinner was to be only for present Students, and so lost the opportunity of joining in the expression of admiration for Mr. Durham as a Surgeon, esteem for him as a man in all the relations of life, and love for him as a dear old friend and fellow-student.—Yours faithfully,

EDWD. HOOPER GATTON.

Brixton Hill, S.W., April 17th, 1894.

Guy's Hospital Students' Club.

Statement of Receipts and Disbursements from September 1st, 1892, to August 31st, 1893.

Sept. 1, 1892. Receipts.	£	s.	d.	£	s.	d.
To Cash Balance at Bankers ...	94	1	5			
„ Petty Cash Balance in hand	2	18	6			
				96	19	11
„ Subscriptions received up to and including August 31st				42	0	0
„ Cash per Clubs' Union (Rent A/c)				119	16	0
„ Cash per Gymnasium A/c ...				3	0	9
„ Cash per Clubs' Union (Grant A/c)				75	0	0
„ Cash Library A/c, Deposits	4	14	6			
„ Cash Library A/c, Subscriptions	0	1	0			
„ Cash Library A/c, Fines ...	0	15	8			
				5	11	2
„ Sale of Wine, Beer and Tobacco in Club				568	6	1
				£910	13	11

Aug. 31, 1893. Expenditure.	£	s.	d.	£	s.	d.
By Furniture A/c				24	4	10
„ Magazines and Newspapers	43	16	3			
„ Printing and Stationery ...	5	10	0			
„ Insurance	0	12	0			
„ Interest on Loan	18	15	0			
„ Fives Court Rent A/c ...	3	0	0			
„ Clerical Expenses	10	10	0			
„ General Repairs	9	6	3			
„ Sundry Disbursements ...	14	13	4			
				106	2	10
„ Gymnasium A/c—						
Cash paid to Hon. Sec....	23	0	0			
Cleaning, Lighting and Repairs	10	8	0			
				33	8	0
„ Library A/c—						
Mudie's Subscription ...	5	5	0			
Deposits returned ...	5	15	6			
Librarian's Honorarium	18	12	0			
				29	12	6
„ Returned Subscription A/c				0	12	6
„ Cost of Wines, Beer and Tobacco				329	12	4
„ Rent A/c				140	16	0
„ Stewards' Allowances ...				238	13	9
„ Balance at Bankers ...	6	4	7			
„ Petty Cash in hand ...	1	6	7			
				7	11	2
				£910	13	11

Audited and found correct on behalf of Clubs' Union,

C. F. WAKEFIELD.
E. HUNTLEY.

Audited and found correct on behalf of Students' Club.

J. H. BRYANT.
B. A. RICHMOND.

September 29th, 1893.

Reviews.

Congenital Affections of the Heart. By George Carpenter, M.D. London, John Bale. 3s. 6d.

Few of the more generally read text-books give much information on the subject of congenital heart disease, and we have found it difficult to collect well-described cases from any source.

Dr. Carpenter's large experience at the Evelina Hospital has put him in a position to illuminate the subject, and the present little work is calculated greatly to assist the student in understanding a by no means unimportant group of cases. After a brief discussion of the embryology of the heart, a very complete description follows of the various malformations found in these cases. Then comes a general account of the symptoms,

diagnosis and prognosis, and finally, we have short reports of twenty-two cases. These latter form a valuable part of the book, and one rises from their perusal with a sense of better equipment for the recognition in practice of these cardiac anomalies. After all, the most practical point in the matter is the question of prognosis, and we could have wished that the author had grouped his facts with more special reference to this. We are shown one of these little blue babies, and are asked to say whether it will live, and, if so,—how long? The answer must always be difficult in most cases, but practitioners will feel better qualified to give it after a careful perusal of Dr. Carpenter's work.

Medical Pathology. By Drs. Herringham, Garrod and Gow. London, Ballière. 7s. 6d.

This manual appeals more particularly to Bart.'s men, since it is written with special reference to the Bartholomew's museum. For all that, it will prove of use to students of pathology generally, being well and clearly written. The volume is excellently printed and well bound. It will be a fortunate day for Guy's when a similar manual is written for use in our own museum.

Immunity.

A Paper read before the Physical Society, March 3rd, 1894, by Mr. E. A. Peters.

Mr. President and Gentlemen,—The subject of immunity is one of lasting interest to all of us, for the study of it is bound up with racial changes and the prevention of those diseases due to microphytal origin, which carry off about 27,000 of our population in Britain annually. There are theories concerning the phenomena of immunity, but the actual processes are uncertain.

Absolute immunity is rare, but the results of the factors which bring about such a condition may be studied with reference to the specific diseases. I, therefore, propose to describe any pertinent features of these, and then to pass on to phenomena considered with a view to explanation of immunity.

In considering tubercle, we have to do with a very complicated subject in which no actual immunity has been produced in man, though destruction of the bacilli was said to have been caused in animals by Koch's tuberculin. Infection with tubercle bacilli is common in man and the ox. Those bacilli affecting the ox are smaller and shorter than the human form, though an examination of human tubercle bacilli shows that measurements vary from 1·5 μ to 4 μ. The tubercle of the ox is more virulent than that of man, but is of the same kind. The species infecting fowls are different. In man, tubercle varies in virulence. Scrofula is ascribed by some authorities to small doses of the poison, while others have shown that the bacilli are indeed identical with the tubercle bacilli, but of less virulence. Lingard has, by cultivation in guinea-pigs, restored the virulence to the ordinary type. Tubercle bacilli require the addition of eight per cent. glycerine to the ordinary agar medium, when they develope well, and one of virulent type producing acute tuberculosis in animals. Outside the body, tubercle bacilli do not flourish, but soon die under the influence of dryness, and of light especially (Ransome); however, they exist in milk from fourteen to thirty days. In a buried condition it has been shown that the bacilli will live for years (Schottelier).

Tubercle bacilli without spores are killed at a low temperature, but the spores will escape 100° C. (Klein). The distribution of tubercle is very great, it accounts for fourteen per cent. of all deaths, while Arloing has calculated that one out of six cattle are affected, and so, if the meat were infective, 170 people would be exposed to infection.

The methods of infection are—

1. *Traumatism*, followed by septicæmia (only known in animals), or local ulceration, depending on virulence. Local infection of the skin; tubercular cutanea verrucosa is found on the hands of men dealing with tuberculous bodies.

2. *Respiratory.*—Pathology shows this to be the more common form. It may lead to general tuberculosis. This has been experimentally confirmed in animals; or, more commonly, a local form of ulceration with a varying amount of repair on the part of the organism; from this the general blood condition of acute tuberculosis may take place by the breaking down of a caseous gland or secondary mechanical infection, *e.g.*, of alimentary canal, and probably larynx. (Compare affection of genito-urinary tract from primary source in kidney, or other section of the tract.)

3. *Alimentary.*—This is rare in adults, and when present is believed to be usually due to mechanical secondary infection from swallowed sputa.

There are fewer deaths from phthisis annually, though the amount of meat eaten is considerably greater than it was; besides, experiments with the expressed juice of cow's flesh gave only ten per cent. positive results under the most favourable conditions of inoculation. In man, direct infection from human milk is probably rare, twenty-nine cases only of tuberculous mammary disease being on record. In the cow, however, the udders are very frequently affected, insomuch that Macfaydean found tubercular inoculation resulted by inoculating milk of tuberculous cows in seventy per cent. This is a very fertile source of tuberculosis in children.

The two periods of life with the greatest percentage of deaths from tubercle is early adult life and infancy. In the last it is fourteen per cent.; these are the Registrar-General's returns. In hospital practice the percentage is much higher: one-third of all children dying in hospitals are destroyed by tubercle. Tuberculosis appears in children after three months of extra-uterine life, and more frequently in hand-fed children.

In fifty per cent. of these deaths the mesenteric glands are affected, while in twenty-five per cent. there is

intestinal tuberculous disease. Accordingly, we may conclude that the tuberculous material enters by the alimentary canal, and infects the body more frequently in children than at any other time of life.

Acute tuberculosis or general infection by means of the blood is a commoner form in children than in adults. Hence we may conclude that the blood and general tissues are less resistant to tubercle in childhood than at other periods of life.

There is little difference in the exposure of the respiratory system to tubercle in children and adults, excepting in one of duration. Hence, again, though the food of children contains a greater amount of virus, and that of adults is not free from it, we may suppose that the alimentary canal in children offers less resistance; one might say the alimentary tissues are less immune than in adults.

The hereditary influence is a difficult one to deal with. There is on record a case of the direct transmission of bacilli from mother to fœtus in utero, but no signs of tubercle are recognised till three months after birth. Authorities are adverse to recognising a usual infection in this way. Burdon-Sanderson alludes to something operating before birth. In animals direct transmission is rare, as in the case of Guinea pigs (Vigual). Calves from tuberculous mothers become tuberculous, though fed from birth on healthy milk.

The probability, therefore, is that in the case of infants the two common causes are—

1. Direct transmission from food.
2. Maternal transmission.

With reference to the cases of tuberculosis in young adults, hereditary influence is very great, as also are surroundings and circumstances of life. It is open to us to consider that in these cases there is some hidden focus, or what is probably more frequent, a general predisposition of body and habits which enables tubercle bacilli with their general distribution to form colonies in their tissues.

Tuberculous foci are, however, frequently of long standng, and those in glands and bones more commonly are the cause of further tubercular trouble than other foci. Another factor in the infection of tubercle has been brought up lately by Délèpene—that is pre-tubercular conditions. In the healthy lung tubercle does not readily grow, but as soon as certain morbid changes obtain then a suitable nidus for tubercle is formed. Thus, in a drunkard—otherwise a healthy man—the lung bases become dull, due to a hæmorrhagic condition; the injured part was swarming with tubercle bacilli. Again, in a strong man affected with an aneurysm which pressed on the vagus, bacilli were found in quantity; again, in a case of spinal trouble high up, tubercles were numerous, though apparently no tuberculous tissue had been formed.

Besides, we have the clinical evidence of the liability to phthisis after acute diseases, especially measles and influenza, and after the chronic changes in diabetes and congenital heart disease. In all these cases it is the lung which is affected, and these phenomena go far to explain the existence of basal phthisis. The mouth undoubtedly is a garden of germs, but even there tubercle bacilli are not commonly, if ever, found in the greater number of people. The air passages are very effective in stopping the entry of germs; besides this, the nasal secretion has been described lately as possessing decided bactericidal properties. The bronchial mucous membranes are preserved in health almost free from microphytes, but with any condition of bronchitis various species abound. In acute morbid conditions of the lungs this will be further dealt with. By the respiratory path, then, do the bacilli enter in the adult, and, finding in the changed lung a suitable nidus, cause tuberculosis.

It thus appears that actual damage is of great importance in the operation of tubercle affection. In this way susceptibility of tissues is increased.

(To be continued.)

Births.

BERRY.—On April 10th, at Watford, the wife of F. Haycroft Berry, M.D., of a daughter.

GOODALL.—On April 16th, the wife of Dr. E. W. Goodall, of the Eastern Hospital, Homerton, of a daughter.

Marriages.

BLIGH—LAFONE.—At S.S. Michael and George, Cochington, Torquay, by the Rev. H. P. M. Lafone—cousin of the bride—and the Rev. T. S. Rundle, Vicar of the Parish, William Bligh, M.D., B.S., M.R.C.S., L.R.C.P., of the Garlands, Caterham Valley, to Lilian Josephine Lafone, fourth daughter of the late William Lafone, Esq., of Monte Video.

FULLER—PURVIS.—On April 19th, at St. Alphege Church, Greenwich, by the Rev. Brooke Lambert, M.A., B.C.L., assisted by the Rev. C. E. Escreet, M.A., Rector of St. Mary's, Woolwich, Courtenay James Fuller, M.R.C.S., L.R.C.P., of 37, Rectory Place, Woolwich, to Clara Cornwall, youngest daughter of Prior Purvis, M.D. Lond. At home on each Monday after 1st June.

SWINHOE—GLASS.—On April 4th, at St. George's Church, Dunster, by the Rev. G. B. Simeon, Vicar of Dunster, assisted by the Hon. Canon Ponsonby, Vicar of St. Mark's, New Swindon, George Rodway Swinhoe, eldest son of George Money Swinhoe, Esq., of New Swindon, to M. C. Gertrude Glass, second daughter of the late Francis Glass, Esq., of Ellecombe House, Dunster.

Death.

HIRST.—On April 14th, at Chandos House, Guernsey, Emily Mary Christiana, the wife of C. J. Hirst, and widow of the late C. Hilton Fagge, M.D., F.R.C.P., aged 39.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual subscription to the Gazette *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers, who may be desirous of having their numbers of the Gazette *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette,

MAY 12, 1894.

Three Cases of Intestinal Obstruction.

CLINICAL LECTURE BY Dr. WASHBOURN.

Case 1.

Man, æt. 21. No history of injury to abdomen or previous abdominal pain. History of present attack: Ten days before admission, patient was seized with vomiting and diarrhœa. The diarrhœa soon ceased, and the bowels had not been opened for the last five days.

Condition on admission.—Patient complained of frequent paroxysms of pain. There was hiccough and frequent retching; pulse 104; temperature normal; abdomen slightly distended, but not markedly so; some movement on respiration. On the left side there was increased resistance, but no definite tumour. No hernia could be discovered. Percussion showed resonance in front with slight dulness in both flanks. The rectum was empty. Vomit was not and never had been fæcal.

In considering the *diagnosis* of this case, dyspepsia, colic, or any similar condition could be at once set aside. The patient was obviously too ill. The only question to be decided was, as to whether the case was one of acute obstruction or peritonitis. Against the probability of peritonitis were the following considerations: Peritonitis is generally due to some definite cause, such as perforation of a hollow viscus, but our patient gave no history of such a condition; moreover, there was not much distension of the abdomen or tenderness on palpation (though this does not always decide against peritonitis, as in some cases there is little tenderness found). Finally, the history of the illness was far too long for peritonitis to have been likely. We, therefore, came to the conclusion that this was a case of acute intestinal obstruction.

The next question was as to the nature of the obstruction. Acute obstruction may be due to (1) an acute attack supervening upon chronic obstruction, but in the present case history was against this. (2) Hernia. It is of great importance to recognise this cause in cases of obstruction (case here quoted of death from non-recognition of strangulated hernia). (3) Volvulus. This was unlikely in our case from small amount of distension. In volvulus, especially in its commonest seat, the sigmoid flexure there is marked distension. (4) Strangulation by bands. (5) Gut passing through opening in mesentery or foramen of Winslow. This cause is very rare. (6) Intussusception. Against this was patient's age; such condition being far most common in children. It may frequently be recognised on rectal examination or otherwise as a sausage-shaped tumour. In our case, then, strangulation by band was by far the most likely cause; but it must be remembered that no absolute certainty in diagnosis can be attained. These bands may be of various kinds, *e.g.* Meckel's diverticulum, pedicles of tumours (ovarian, etc.), or inflammatory adhesions. Now came the question, where was the obstruction situated? In acute conditions this point is not so important, but in chronic obstruction it is of great importance with regard to the site of operation. It was unlikely in this case to be in the large intestine, because of the slight distension. Where the obstruction is low down the distension is great. It is sometimes stated that with an obstruction high up, the quantity of urine is diminished, while with obstructions lower down, the quantity is larger; but the amount of urine largely depends upon the general condition of the patient.

We had next to determine on the *treatment.* I need scarcely say that you would not think of aperients in such a case as this. In acute obstruction, purging is of the greatest danger to the patient. The two courses we had to consider were laparotomy or treatment by opium. The latter treatment is of no use where the obstruction is due to such a cause as bands; and having regard to the favourable condition of the patient, his pulse, for instance, being excellent, we determined on laparotomy. The only thing which could have made us hesitate was the presence of hiccough, which suggested a possible peritonitis associated with the obstruction. As you know, when obstruction has existed for some time, it is always associated with a certain amount of peritonitis, and these are the cases where diagnosis is so difficult. The operation, however, was fully justified. On opening the abdomen, Mr. Dunn found a coil of intestine adherent to the pelvis in the right iliac fossa. This had passed under a band which stretched from a lump, the size of a small nut, near the intestine, to the abdominal wall. This lump was probably an inflamed gland, which at some time had formed an adhesion with the parietes, the adhesion having afterwards stretched leading to the formation of a band. This band was ligatured at both ends and divided. The intestine was found injected but of good colour. The patient made an uninterrupted recovery.

Case 2.

This case was similar to the foregoing, but offered some additional points of interest. The patient, a

woman æt. 35, was under Mr. Golding-Bird, in 1891, for ovarian tumour. On removal of this tumour, so many adhesions to the pelvic organs were found that a part of it had to be left behind. It is important to note that the woman was spoken of in the old report as being highly neurotic. Since the operation, she has had fairly good health, but had of late suffered from attack of retching and vomiting which recurred fortnightly.

History of present attack.—A few hours before admission patient was seized with violent abdominal pain and retching; the pain was chiefly in the epigastric and hypochondriac region, but was felt also at the back. This continued until admission.

On admission.—Patient was found to have a small, weak pulse, 66. The abdomen was not full or rigid, and moved freely on respiration. The rectum was empty. It will be noted that in this case we had to consider as to whether it might not be pure neurosis, the condition of the abdomen on admission and the neurotic tendencies of the patient making this quite possible. We then had to consider the possibility of abdominal influenza, of renal colic (though the pain was not sufficiently localised for this) of hepatic colic, though there were no signs of jaundice; and, finally, one had to think of gastric crisis. This a possibility always to be borne in mind in these abdominal cases, and the knee-jerks and pupil reflex should, therefore, always be examined. In the present case there was no sufficient evidence of this. The patient was put upon milk, and given a little morphia in order that the symptoms might be further observed. There seemed to be some improvement at first, but thirty-eight hours after patient was first seen there had been no opening of the bowels, and no passage of flatus, while the abdomen was more distended. The distension even now was not great; but as we had carefully examined the condition of the abdomen when she first came in we were able to feel sure of an increased distension.

We were thus led to the *diagnosis* of acute obstruction. The evidence against peritonitis, and in favour of the obstruction being in the small bowel, was the same as in case 1. As to the probable cause of obstruction, the previous history of the ovarian tumour made it highly probable that we had to deal with a contraction of the lumen of the gut, owing to previously formed adhesions. In this case, also, we decided on operative treatment, and an incision was made just to the right of the old ovariotomy incision. Mr. Dunn came almost at once upon a tight band about two inches in length, with a portion of gut passing beneath it. We were thus wrong in expecting to find contraction of the lumen, but fully justified in recommending surgical treatment. A second and longer band was found, and, together with the other, removed. The patient made a rapid recovery, and when the wound was dressed, seven or eight days after the operation, it was found to have healed by primary union. There has been no return of symptoms of obstruction.

The difficulties of diagnosis will thus be seen to have been of a different nature in the two cases. In the first we had a longer history, and an obviously severe condition; in the latter, we had to exclude the possibility of simpler conditions exaggerated by neurotic tendency.

CASE 3.

The patient, a woman æt. 55, had an attack of vomiting last Christmas, in which she brought up what was described as clotted blood, and she was for a time very ill. This was followed by a period of constipation, and the patient herself states that her bowels were open only once in three weeks. Six weeks ago she had another attack of vomiting, with severe abdominal pain. These symptoms continued and became more severe, but there had not been complete obstruction.

On admission.—The abdomen was very much distended, moving but very slightly with respiration. Several swellings were visible, looking like hypertrophied coils of intestine. There was no definite localised tumour, and the abdomen was resonant throughout. The rectum was empty. When distended intestinal coils are seen in an adult they always indicate a condition of chronic obstruction. The coils are only visible when the muscular coat has become hypertrophied owing to the peristalsis. It was difficult to associate the history of sudden vomiting of blood with any likely cause of chronic obstruction.

It was possible, of course, that a gastric growth or ulcer might have existed which had perforated, and thus caused peritoneal adhesions, but there was no clear history of such having existed, and we thought that the hæmatemesis probably followed from cirrhosis of the liver, although, owing to the distended abdomen, it was difficult to make this out. As in the previous cases, we had to decide where the obstruction was probably situated, and, as I have said, this point was of more importance in a case of chronic obstruction like the present. It is useful to observe the position of the coils. When the obstruction is in the small intestine, the coils are seen to be transverse, when in the large they are vertical, but in our case, the coils were irregular and helped us very little. But the distension was very marked, and therefore strongly suggested that the large bowel was affected; moreover, there was distinct bulging in both flanks, and this was in favour of obstruction of the rectum or sigmoid flexure. When the obstruction is higher up in the large bowel, as for instance, in the transverse colon, the bulging is found in the right flank only.

In this case, therefore, the evidence was all in favour of obstruction in the region of the sigmoid flexure or rectum. Moreover, having regard to the age of the patient, and the history of the case, there was every probability that the cause of the obstruction was carcinoma, and this, as you know, has its commonest seat in the lower part of the large bowel. We therefore decided, without hesitation, that the proper course was to recommend colotomy. Left inguinal colotomy was performed by Mr. Dunn, and the patient has since experienced complete relief from the symptoms, and is going on well.

Notes on Dr. Shaw's Demonstrations in Pathology.

RENAL GROWTHS.

BENIGN.

Fibroma.—Fibromata of the kidney are generally on the cortex, and are of a glistening white appearance. They may be distinguished from miliary tubercle (1) by there being fewer; (2) by there being no miliary tubercles in other organs of the body.

Adenoma (2059[64]).

Nævoid growths.—These sometimes occur in the kidney, but more frequently in the liver, and may be mistaken for hæmorrhages.

MALIGNANT.

Primary.—Carcinoma (2061[10]).
Sarcoma (2054).

Clinically these cannot be distinguished, and it is often difficult *post-mortem* until sections are cut.

Secondary.—Hodgkin's disease (2062[20]).

Hodgkin's disease gives rise to isolated growths in the kidney, whereas leucocythæmia causes a diffused infiltration throughout the organ.

Melanotic sarcoma (2062[5]).
Carcinoma (2056[40]).

PELVIS AND URETERS.

Double ureter (2078).—Worth remembering in operations for stone.

Pyelitis (2065[32], 2035[84]).

Causes: (1.) Irritation of a stone in the pelvis.
(2.) Ascending nephritis.
(3.) Tuberculosis.

HYDRONEPHROSIS.

PASSIVE.—This is very rare; due possibly to a permanent dilatation through paralysis.

OBSTRUCTIVE.

Pelvis.—Calculus (2072[71]).
Aberrant vessel (2071[51, 25]).

Ureter.—Calculus (2079[56]).
Stricture 2079[62]).
Compression.

Bladder (2070[50]).—A stone fixed in the back of the bladder may obstruct the orifices of both ureters.

Urethra (2080, 2080[60]).

Uterus (2067[25]).

Vagina (2071[50]).

Conditions of the kidney produced by hydronephrosis.—After hydronephrosis has continued for some time, it dilates the pelvis, then the calyces, and finally goes on to atrophy of the renal substance—hence advisability of frequent tappings in such cases.

Pyonephrosis occurs when ulceration takes place at the seat of obstruction. It is also associated with tubercle, in which case there is not often hydronephrosis, but suppuration goes on from the beginning.

BLADDER.

MALFORMATION.

Extroversion (2083[10]).

Sacculation (2087[41, 75, 86]).

It results from the fact that the muscular fibres of the bladder are ill-distributed, so that where they are ill-developed there are bulgings of the bladder.

The sacculus tends not to empty itself of urine, the muscular fibres outside being deficient—hence a stone may form and be hidden away.

HYPERTROPHY (2084[5], 2089[12], 2088[50]).

More marked on the anterior wall. It occurs whenever there is more work to be done, (1) from obstruction, *e.g.* stricture of the urethra; (2) from an excess of urine passed, *e.g.* diabetes.

DILATATION (2089[25]).

CYSTITIS.

Idiopathic (2095[02]).—Due to (1) an unnoticed gonorrhœa; (2) to the passage of a catheter.

Paralytic (2091[50], 2093, 2095).—Occurs in cases of paraplegia, due to (1) absence of trophic nerve influence; (2) passage of catheter; (3) to micro-organisms making their way up the urethra, which is kept patent by the constant dribbling of urine.

Calculus (2100[50]).

Foreign body (2103[70]).

Tuberculous.—Miliary (2092[55], 2102[4]).
Ulceration (2033[30], 2102[5, 6, 11, 12]).

Infection may arise from the ureters or be conveyed by the blood.

Changes in cystitis.—(1) Mucous membrane becomes inflamed; (2) deposit of a membranous exudation upon the mucous membrane of the bladder—hence called diphtheritic inflammation; (3) removal of parts of mucous membrane, (*α*) by sloughing in large pieces; (*β*) by ulceration in small pieces; (4) bladder may become adherent to neighbouring parts, *e.g.* the rectum forming a recto-vesical fistula.

From the Gazette's Special Pathologist.

H. L., SALFORD.—Adeno-carcinoma of breast.

G. W. N. F., YEOVIL.—No tubercle bacilli present.

A., TUNBRIDGE WELLS. — (1). No tubercle bacilli recognised. (2). S. H. Tubercle bacilli present.

G. F. H., BALHAM.—Tubercle bacilli present.

H. V. H., WANSTEAD.—No tubercle bacilli present.

R. M., SANDRINGHAM.—Tubercle bacilli present.

PATHOLOGIST.

Specimens for examination and description in this column should be addressed to H. HUNT, GAZETTE, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Diseases of Circulatory System.

MARY 27.
PHILIP 1 and 24.
39.
STEPHEN 10 and 2.
} Mitral regurgitation.

28. Mitral regurgitation: also ascites, pleuritic effusion and large liver.

MARY 33
PHILIP 10
} Mitral stenosis and regurgitation.

MARY 50
PHILIP 36
} Mitral stenosis.

MARY 17. Mitral and aortic regurgitation. Enlarged lung, spleen and lymph glands.

MARY 21. Mitral and aortic regurgitation. Ascites.

PHILIP 25. Mitral stenosis and regurgitation. Aortic regurgitation.

STEPHEN 25. Mitral and tricuspid regurgitation. Ascites.

PHILIP 35. Tricuspid regurgitation. Empyema.

Renal Cases.

MARY 1. Renal calculus. Nephrolithotomy.
3. Renal calculus. Nephrolithotomy.
14. Nephralgia. ? Cause.
31. Tuberculous right kidney. Nephrectomy.

STEPHEN 25 and 27.
MARY 18.
} Acute tubal nephritis.

MARY 6. Chronic interstitial nephritis. Hypertrophied heart.

PHILIP 9. Gout and chronic interstitial nephritis.

PHILIP 23 and 31. Chronic tubal nephritis.

Diseases of Respiratory System.

MARY 2, 12, 26, 32, 45, 49 (PHILIP 17, 26, 40), STEPHEN 38. Phthisis.

MARY 9. Bronchitis.

MARY, cot 51. Broncho-pneumonia.

cot 56.
STEPHEN 23 and 24.
} Empyema.

MARY 47. Hæmoptysis. Bronchiectasis. ? Phthisis.

PHILIP 7 and 18. Pleurisy with effusion.

12. Old pleural adhesions. Lardaceous disease.

Nervous Diseases.

MARY 3. Peripheral neuritis.

19.
PHILIP 25.
} Optic atrophy. Cerebral tumour.

MARY 42. Diffused myelitis.

PHILIP 38. Spastic paraplegia. Chronic myeletis.

2. Early locomotor ataxy.

MARY 21. Functional paraplegia. Mitral regurgitation.

PHILIP 3. Right hemiplegia.

STEPHEN 3. Right hemiplegia and facial paralysis. Pontine lesion.

MARY 22. Epilepsy.

Rheumatism.

MARY 7, 17. STEPHEN 36.

Typhoid.

MARY 6, 20, 23, 29, 34, 41.

PHILIP 17, 37. STEPHEN 8, 21, 37.

Liver Diseases.

MARY 25. Hæmatemesis. Cirrhosis of liver.
36. Epistaxis. Cirrhosis of liver.

PHILIP 26. Enlarged liver and spleen. Cirrhosis of liver.

MARY 44. Carcinoma of liver.

PHILIP 4. Enlarged liver. Jaundice.

Alimentary System.

STEPHEN 1. Stricture of œsophagus.

MARY 35. Gastric ulcer.
37. Carcinoma of pylorus. Dilated stomach.
cot 57. Diarrhœa. Tuberculosis. Ulceration of intestine.

STEPHEN 31. Dysentery.
29. Carcinoma of stomach.

Miscellaneous.

MARY 30. Hodgkin's disease.

PHILIP 40. Pernicious anæmia.

STEPHEN 9. Adenoma sebaceum.
34. Adeno-myxœdema.
6. Tuberculous peritonitis.

CASES UNDER DR. PYE-SMITH.

PHILIP.

22. J. O'D., æt. 49, boiler-maker. Admitted for pain and numbness in left chest, increased by exertion. Had rheumatic fever twenty years ago; when quite young suffered occasionally from fainting fits; drinks a little beer, no spirits; smokes cigarettes a good deal; no history of syphilis. About three years ago noticed uneasiness, fluttering and oppression about the heart during his work, necessitating sitting down to rest frequently. This becoming worse, patient came to Guy's for treatment.

On admission (April 3rd, 1894.)—Temperature 96, pulse 86, respiration 20. *Chest.*—Whole surface of left chest, both back and front, tender; this especially marked in the third and fourth left spaces in front and behind. There is also pain in this region, increased by exertion or excitement. *Heart.*—No præcordial dulness; epigastric pulsation; a short, soft systolic murmur at apex, probably functional; second sound "pinging" in character. *Lungs.*—Præcordial area resonant, otherwise normal.

Eyes.—Left lid droops considerably; pupils contracted; they react to accommodation, not to light; the sight of the left eye is weak. *Ears.*—Patient does not hear a watch ticking, however near; questions are heard pretty well. The right knee-jerk is absent, the left fair. Patient has, from time to time, experienced shooting pains in the limbs, chiefly the calves of the legs; he walks quite well.

Treatment.—Full diet. Mist. Pot. Iod. ʒi. t.d.s. was first tried; afterwards Liq. Arsenicalis ɱv., Inf. Quassiæ ad. ʒi. t.d.s.: p.c.

Dr. Pye-Smith considered the case to be locomotor ataxia in its early stage. Patient improved somewhat under treatment; but on his discharge, on May 8th, the symptoms were about the same, the chest, however, being slightly better.

MARY.

29. A. T., æt. 24. Married, has had one child, and was at the time of admission four months pregnant. Has, as a rule, been healthy, though suffering occasionally from sick headaches. On April 18th patient was taken ill with pains in the back and headache, and loss of sleep.

On admission (April 25th).—Temperature 102·4; pulse 132, soft, feeble, not dicrotic; respirations 60, very rapid in proportion to pulse and temperature. *Tongue.*—Flabby, tremulous, dorsum coated on either side by a line of white fur; in the middle line is a brown fur, the tip is raw-looking. *Urine.*—Sp. gr. 1020, scanty, high-coloured, with a trace of albumin; no blood nor sugar. *Chest.*—Healthy. *Abdomen.*—Prominent, liniæ gravidentes, a few spots scattered here and there over the surface, slightly raised, pale pink, fading on pressure. There is no tendency to palpitation. *Ears.*—No discharge. *Eyes.*—Left disc swollen, tortuous and enlarged veins; right disc normal. Patient complained of great pain in head and sore throat.

25th. Temperature, 103·2. Patient had a fit with clonic convulsions in the night, and delirium.

Diet.—Milk, ice, lemonade. Icebag to head, mouth wash of lotis nigra and glycerine. Temperature kept below 104 by sponging and antifebrin.

Dr. Pye-Smith considered the case to be enterica. The edge of the spleen can be felt. There is no diarrhœa.

28th. Headache gone; bowels opened three times; motions liquid, dark brown. Patient better, except throat.

May 1st. Bowels opened, motion tinged with blood. Patient aborted this evening, not much hæmorrhage; passed a good night.

7th. Patient improving steadily; throat still very uncomfortable; temperature keeps up, and requires frequent sponging. Spots continue to come out.

CASES UNDER DR. TAYLOR.

STEPHEN.

17. Angina Pectoris. W. H., æt. 29. Admitted for attacks of pain in chest, starting from basal region of heart.

Family history.—Father suffered from rheumatism.

Personal medical history.—Patient had rheumatic fever eight years ago. No history of alcohol, gonorrhœa, or syphilis.

Present illness.—For the last two years patient has been suffering from shortness of breath on exertion, and attacks of dizziness; did not think he had heart disease. Last December had first attack of angina pain, came on while out walking. Pain was in region of heart and extended down left arm and through chest to left scapula. It was a sharp stabbing pain, and patient had to go in a house and sit down, couldn't speak or cry out, and felt he couldn't get his breath, and had a horrible fainting feeling, and thought he was going to die.

A week ago patient had second attack of pain. Since then has had one or two attacks daily to day of admission, 19th April. C.O.A. cardiac impulse, sixth space nipple line. At apex, soft systolic murmur, also second sound is prolonged into a rumbling noise, probably transmitted from the aortic murmur. Well-marked aortic to-and-fro murmurs heard. Well-marked aortic thrill. Water-hammer pulse. Capillary pulse lower end of sternum retracts during systole.

Had attacks of pain day of admission, then one attack three days after. Has had no recurrence since, and patient, who now gets up, says he feels quite well.

Treatment.—Rest a fortnight in bed. Liq. Trinitini and Strychnine.

MARY.

38. S. P., æt. 41, married. Was admitted April 24th with tenderness and pain in the abdomen, nausea, retching, flatulence and vomiting. There is no family history of tumour, the father and mother being both well, æt. 67 and 66 respectively.

Patient's medical history begins with her present complaint about eighteen months ago, *i.e.*, October 10th, 1892. It started with attacks of abdominal pain, sometimes extending to the back, nausea and retching, to which was rapidly superadded vomiting, bearing no relation to food. Nine months later, a small, rounded, painful, tender, hard tumour was observed in the middle line above the umbilicus. The other symptoms increasing in severity, and producing general emaciation. A month later, patient vomited "coffee grounds" at intervals, and had slight occasional hæmatemesis. Her diet had by this time been reduced to peptonised milk and nutrient enemata, while the œsophageal tube was passed into the stomach several times without relief.

On October 10th, 1893, she was admitted into Clinical ward for the same symptoms, and the tumour was then more accurately defined by palpation and percussion, while it was hardly obvious on inspection. All the other organs were found normal. Dr. Taylor then diagnosed gastric carcinoma and hæmatemesis.

She was discharged, somewhat relieved, November 1st. and was re-admitted under Dr. Taylor, April 24th, 1894, During the interval her symptoms had become more severe. On admission, the abdomen was flaccid, moved well with respiration, and presented a more or less

bulging, permanent tumour, with a long transverse diameter, and a short median vertical diameter, just above the umbilicus. It was painful, tender, well-defined, and dull. A peristaltic wave of contraction passed from the left costal margin as a globular swelling, downwards and inwards towards the umbilicus, then upwards and to the right, ending a little beyond the middle line.

Stomach resonance encroached upon the cardiac, splenic and left pulmonary areas.

The pain is of a clawing, tearing character, and occupies the epigastric triangle, also sometimes the back.

Retching and vomiting are troublesome, but have no relation to food. Abundant sarcinæ ventriculi are found, but no blood. Dr. Taylor diagnosed pyloric cancer with dilated stomach, and pointed out that this case was of a duration above the average. The other organs are normal.

44. E. E., æt. 38. *Diagnosis.*—Malignant disease of liver.

Admitted April 18th.—Not been well for the last eighteen months, but has had to take to bed for the last six weeks on account of the intense pain in the region of the liver. Constantly had jaundice, but not more frequently of late; no history of gall-stones. Liver dulness begins at upper border of fourth rib and extends vertically downwards for ten inches; the lower edge can be felt just above the right anterior superior spine of the ilium, on the same level as the umbilicus and obliquely upwards on the left side. Its surface is hard, and on it can be felt three large hard masses, oval in shape, and each about four inches by two. One is situated in the lower part of the right lumbar region, one in adjoining parts of the epigastric and right hypochondriac regions, and the last in the left hypochondriac and lumbar regions.

On vaginal examination a small hard mass can be felt, situated to the left of the cervix uteri, which it seems to fix, but it is not connected to the mucous membrane of the vaginal wall. There is no evidence of growth elsewhere. No ascites nor jaundice since admission. Patient has a troubled prostrated look, and has lost a lot of flesh lately.

STEPHEN.

1. B. T., æt. 26. Admitted for dysphagia. Patient looks a strong, healthy man, but says he has lost about one and a half stone in weight the last six months. The abdomen is not retracted.

Previous medical history.—Good. Patient has been in the Army the last eight and a quarter years, seven years of which he has spent in India.

History of present illness.—On September 6th, 1893, patient was cleaning a rifle, which went off, the bullet entering his left chest at a point in the third interspace an inch within the nipple line. Patient, who had been out in the sun all day, thinks it "affected his head," for he picked up a bottle which was standing by and swallowed some of the contents, the bottle containing strong hydrochloric acid. Almost immediately after swallowing the acid, patient vomited up a considerable amount of blood, and for six weeks subsequentiy patient continued to spit up blood. For three days patient lost his voice completely, and it was three months before he could speak at all well. Ever since the accident patient has been unable to swallow solid food, and for some time patient had very great difficulty in swallowing liquids, but has been improving gradually lately. Patient has no pain even when swallowing. Patient is unable to bring anything up from his stomach now when he feels sick, and had a bad attack of sea-sickness on his way home without bringing anything up.

A bougie 1 cm. in diameter with a tapering end was passed down the œsophagus sixteen inches, but would not go any further. It also met with considerable obstruction nine and a half inches down. A bougie has not been passed right into the stomach, even the smallest meeting an impassable obstruction sixteen inches down. Patient says he swallows much more easily since the bougies have been passed.

Diet.—Egg and milk, gruel, bread and milk, tea

Compare pathological specimens 3564, 3565, and 3566.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN.

8. H. M., æt. 22. Admitted April 23rd, complaining of inability to pass his motions or urine, and of pain in the right iliac region. The illness commenced on the 17th, patient vomiting a lot of green liquid, doing so four or five times during the night, which lasted on and off until admission; bowels not opened since 17th, and no water since 21st, excepting that it keeps dribbling away. The pains across the abdomen were much increased on the 21st. Patient has had no food except soda and milk since 17th, all of which has been vomited.

23rd. Patient's face pinched, eyes sunken, abdomen distended and tender in right iliac fossa and more resistant; veins distended, pulse 80, abdominal muscles rigid, temperature 102·4.

24th. Patient has passed water voluntarily, sp. gr. 1027, free from albumin and sugar; also some motions containing blood and pus.

May 1st. Patient much better; has had no solid food, milk being his only diet.

There seems to have been a little peritonitis, which probably started in the vicinity of the vermiform appendix. Pulse and temperature normal. On percussion there is dulness over right iliac region, and a hard lump can be felt just above the middle of Poupart's ligament extending along line of Poupart.

4th. Area of dulness is diminished, lump not so hard nor so large; very little pain in iliac region; motions and urine normal and passed normally.

Cases under Mr. Davies-Colley.

Cornelius.

4, 5 and 15. Three cases admitted for fractured patella. In No. 15 the fracture was due to direct violence, and transverse, with a separation of nearly an inch. The fragments were united by a wire passed from below behind the fragments through the quadriceps tendon, and then up again in front, the ends of the wire being twisted at the upper border of the patella. A Croft's splint was applied. In No. 4 the fracture was also due to direct violence, and transverse. There was no separation at first, but after an hour or two there was a quarter of an inch between the fragments. A Croft's splint was put on. In No. 5 no sign of fracture was present other than extreme tenderness, especially at the lower part of the inner border, occasional crepitus, and a transverse groove. The leg could not be lifted. Mr. Davies-Colley pointed out the flaw in this evidence; there was no abnormal mobility. The crepitus and the groove were most probably due to inflammation in the bursa, and the tenderness to tearing of fibres attached to the edge of the patella. A Croft was put on. The patella remains tender, but the leg can be lifted, and no separation or abnormal mobility has been detected, and so the case is, in all probability, not one of fracture.

6. Stabbed in the neck with a penknife. The wound caused very severe hæmorrhage both externally and into the mouth. Compression of the common carotid was maintained till the patient was carried to the theatre and, after exploring the wound, the external carotid had been tied. The patient was so drunk and collapsed from hæmorrhage that no anæsthetic was given. On the ninth day the wound was found to be closed by primary union. The hæmorrhage was from the facial artery, and probably, though this was not proved, from the lingual at the base of the tongue.

17. Fell and struck his scapula against the hard corner of a seat. Did not complain of pain till two days later. Then there was a swelling, hard, tender, and causing much pain, with pyrexia. Fluctuation developed in a day or two, and on incision pus was let out and the infraspinous fossa found to be stripped of periosteum.

18. Injury to hip. Three weeks before admission the great trochanter was widened; loss of movement and great pain in the joint; no shortening, very slight eversion of foot, and some fulness in Scarpa's triangle. At first thought to be extracapsular impacted fracture of neck; but the widening of the trochanter subsequently seemed less than was at first thought. It is doubtful whether there is any fracture of the neck. There is still considerable pain, felt mostly in Scarpa's triangle now; the limb is treated by weight-extension.

Lydia.

21. Æt. 20. Five years' history of stiffness and swelling in elbow-joint with pain, especially at night. Sinus in front of elbow discharging eight months. The joint feels loosened, and a peculiar grating is felt on movement. Complete extension impossible; movement through about 60° at elbow. Pronation limited to about 10°. Muscles of arm wasted. The joint was excised on April 27th through a vertical posterior incision; the olecranon was displaced inwards, owing to erosion of the articular surface of the humerus, so that to ensure the safety of the ulnar nerve, it had to be removed with bone forceps before the inner part of the joint could be freed. In the outer part of the olecranon was a porous sequestrum one inch long, half buried and covered in by gelatinous tuberculous material replacing the articular cartilage of the greater and lesser sigmoid cavities. The coronoid process of the ulna was much elongated and projected forward beneath the internal condyle. After removal of the diseased bone the wound was closed without a tube, the limb put up straight, and not dressed till ten days later, when the stitches were removed, the wound having healed, and the limb was put up at a right angle.

5. Complained of pain in left hip seventeen days before admission, history of kick in the groin. Admitted with flexed abducted hip-joint, swelling, pain, and tenderness in Scarpa's triangle; resistance to any attempt at moving the joint; temperature 100. At first there were no signs of abscess, and the acuteness of the onset and course of the trouble made tubercular hip disease improbable. Traumatic epiphysitis, with perhaps some amount of separation, was thought to be the condition. Weight extension was employed. In a few days, however, fluctuation was found over the interval between the tensor fasciæ and rectus, which was transmitted also by pressure over the iliac fossa. No signs of spinal disease being present the diagnosis presented at the time of going to press an interesting problem.

Luke.

6. Strangulated inguinal hernia. At the operation some inches of gut were found to be very dark and somewhat dulled, although strangulation had only occurred some six or seven hours before. Great difficulty was experienced in reducing the gut, of which about three feet were protruded and exposed for nearly the whole of the operation, which lasted an hour. Finally, reduction was effected by returning the part that had been nipped most severely first. On the 10th day healing had taken place by primary union. The pillars of the ring were stitched together, but no attempt was made to effect a radical cure.

15. Congenital wryneck, left-sided. The distance between the external canthus and angle of the mouth is a quarter of an inch less on the left side than on the right, and the left side of the face generally is smaller than the right. After division of both parts of the sterno-mastoid, an apparatus was applied composed of a band of webbing round the forehead and occiput, and one in the coronal plane under the chin. From the crossing of these bands on the left temple a rubber band was passed downwards and backwards under the right arm to a girdle of webbing round the chest, so as to

rotate the head to the left. From the crossing of the webbing on the right temple another rubber band passed directly downwards to the girdle, so as to tilt the head on to the right shoulder, and so to produce a right-sided wryneck correcting the left-sided deformity.

Cases under Mr. Lucas.

Charity.

2. H. S., æt. 52. Admitted for an inflamed umbilical hernia. She has had the hernia four years, and on several occasions it had been slightly inflamed, but had always been reducible. Four days before admission it suddenly increased in size during a fit of coughing, and was irreducible. It became inflamed and painful, and the bowels confined, but she was not sick.

On admission.—The hernia was about five inches long and three inches broad, red, hot, tender, irreducible, and with a hard nodular feel. Patient not much collapsed, pulse 70, good. The likelihood of gangrene determined operation. On making an incision, the skin was found firmly adherent, and the sac obliterated by the adherent inflamed omentum, except at one spot where the peritoneal cavity was opened. The mass of omentum was very hard and fibrous, in it were a number of small cysts, containing turbid foul-smelling fluid. In cutting this away, a piece of imbedded intestine was opened, and was found to be a diverticulum of the transverse colon. Most of the mass was cut away, the remnant of sac tied and the intestine left open. The skin could not be brought together on account of its adherence all round. Since the operation (four days ago) patient has done extremely well, has not been sick, and is now taking two pints of milk in twenty-four hours. No fæces have passed by the wound. The bowels have not been opened, but her condition clearly shows that there is no obstruction.

22. M. S., æt. 52. Admitted for swelling of left arm. She had first felt pain a month before at about the middle of the outer side of the arm; this increased, and a swelling appeared at the painful spot. This was followed by swelling of the hand, gradually extending upwards. Has lost flesh.

On admission.—Patient looks ill and decidedly cachectic; temperature 99. The left hand and arm are very œdematous up to a point a little above the middle of the arm, the upper few inches being somewhat red, and markedly tender. Above the œdema a large, hard, painless swelling of the humerus could be felt, extending nearly up to the shoulder. No enlarged glands in the axilla. The diagnosis was growth of the humerus.

After admission the redness rapidly increased, and fluctuation was felt at the most tender spot. The temperature also rose to 101 in the evening. An incision was made and about a pint of thick greenish-yellow pus escaped.

Accident.

29. Patient admitted for cut throat, five inches long, being three inches on left side and deeper than on the right. The external jugular vein was cut on left side, the skin was jagged in places as if the razor in going from left to right had been used as a saw. The thyroid cartilage was almost cut through about its middle; this was sewn up by salmon-gut, and the middle three inches of skin incision also sewn up. The sides of the larynx and trachea were packed with iodoform gauze, the ends left hanging out. Patient, who was put on nutrient enemata, is doing well.

—. Man brought in unconscious; reported to have fallen four feet six inches. When admitted was quite unconscious; bleeding from nose and right ear. Pulse, 50, full and strong; respirations 22; no stertor. The vault of the skull was fractured with a depression two inches by two inches in left frontal region, with probably a fractured base and ethmoid. Vomited soon after admission, and came round so that he answered when spoken to loudly, then relapsed into total unconsciousness with stertor. Mr. Lucas trephined over the depression and removed a large loose piece of bone, having exposed the middle meningeal artery. He recovered slightly for a time, moving his left arm and groaning, but died three hours later.

Cases under Mr. Golding-Bird.

Lazarus.

17. Admitted April 28th for recurrent hydrocele, operated on two years ago by Mr. Symonds. A fluctuating reducible swelling in right side of scrotum, with a prominent projection on the anterior surface. Reduces entirely without gurgle through external abdominal ring; good impulse on coughing. Perfectly translucent.

Treatment.—Hydrocele dissected clear of cord, emptied by puncture, and invaginated like the sac of a hernia by a wire inserted from above through the abdominal wall, so as to block the external abdominal ring.

20. Admitted April 17th. Left axillary aneurysm, at junction of axillary with brachial artery. No history of syphilis. Noticed nine or ten days before admission. Round in shape, size of pigeon's egg, expansile pulsation, a distinct bruit to be heard, emptied by compressing subclavian. Left radial pulse less forcible and more easily compressed than right.

Treatment.—Ligature of axillary artery just above the tumour. Tumour left untouched.

7th. Wound healed by primary union. No return of pulsation in tumour. Circulation of hand good from the first. Radial pulse not reappeared.

Accident.

3. Admitted April 13th, for fractured humerus and olecranon process of left arm. Great amount of blood effusion in arm. Fracture of humerus just at the insertion of deltoid.

Treatment.—Rest on a very obtuse-angled splint, with Gooch's splint for upper arm. Extension by weight attached to the bend of the splint.

Martha.

Admitted May 7th for intestinal obstruction. Bowels not opened for eighteen days before admission. Castor

oil and various enemata had been tried without success. Rectum would not contain more than about half a pint. A good deal of sickness, especially after aperients, but never incessant.

On admission, abdomen tremendously distended; distension uniform. Patient's general condition good. On rectal examination, no stricture, but a mass could be felt as high as the finger could reach. Left lumbar colotomy performed May 8th, intestine being opened at the time of operation. Large amount of semi-liquid fæcal matter came away.

Case under Mr. Lane.

Job.

13. Admitted for recurrent pain in right iliac fossa.

History.—Has had three attacks of pain, accompanied by sickness, constipation, and swelling in the right iliac fossa, since Christmas. On examination, a firm hard mass can be felt, extending from middle of Poupart's ligament to McBurney's spot.

Operation.—The usual incision was made; the peritoneum was thickened and inflamed. A small abscess was found, bounded by the abdominal wall on one side and the appendix and small intestine on the other, the appendix being adherent to intestine, except at its far end. The abscess was scraped out, the appendix separated off as far back as possible, and cut off. Owing to adhesions, it was found impossible to invaginate the stump of the appendix. A small incision was then made through the abdominal wall, outside the primary incision (communicating with the abscess cavity). The cavity was drained by iodoform gauze brought out through the small incision, and the primary incision sewn up.

Patient is making an excellent recovery.

Notes from Out-patients.

Mr. Jacobson's.

Man, æt. 55, complaining of pain and "hot feelings" along inner side of foot in Tendo-Achilles, with *slight* pain in great toe.

Diagnosis: Gout.

Text-book gout is comparatively rarely seen. Some confirmation in the diagnosis of a doubtful case is afforded by the presence of a well-shaped head, with Laycock's teeth, fine big teeth with small necks, strong but very much worn down. Hypochondriasis is a frequent accompaniment, phlebitis (gouty) may be sought, and enquiry made for the history of an old hydrocele.

Hydrocele: Its so-called radical cure by carbolic acid injection. Injected one year ago. Impossible now to tell any difference between the two sides.

The carbolic acid may cause obliteration of the sac; or it may cause adhesions, or lead to the absorption of the fluid without obliterating the sac. Such cases as these have been known to recur even after twelve years' interval, owing to some small piece of the membrane having escaped the action of the carbolic.

Man, æt. 47, with enlarged knee-joint, apparently with slight backward dislocation, with limited power of extension, and considerable fixity of patella. No fluctuation.

? Osteo-Arthritis. No, because (1) Grating very slight indeed. (2) No lipping. (3) Other joints quite healthy.

? Specific. Probably not, because (1) No syphilitic lesions elsewhere. (2) No syphilitic history.

? Growth. Myeloid or periosteal sarcoma. Not myeloid, because patient is too old. Not peristeal sarcoma, because (1) Enlargement is very uniform. (2) There are no distended veins. (3) There is a history of five years' duration.

Chronic arthritis, probably slowly becoming pulpy, was the diagnosis, and the backward displacement may be accounted for by implication of the crucial ligaments. The patient is otherwise quite healthy, and the case, despite his age, is therefore favourable for operation.

Boy, æt. 13, with retained testis, situated in the least unfavourable position, namely just outside the external abdominal ring.

Such a case might be operated on, or treated with Wood's Horseshoe truss, the object of which is to maintain pressure on the ring without irritating the testicle or spermatic cord.

Man, æt. 40, whose tongue presented well-marked leucomatous patches due to old glossitis, and a small ulcer on the edge. One of the patches showed hypertrophy, the other atrophy of the papillæ. The tongue was pointed out as in the "pre-cancerous condition," a condition of chronic inflammation that will not yield to treatment, also met with in the glans penis, the lip, the nipple, and the in breast affected by chronic mastitis.

Guy's Hospital Bicycle Club.

The Club rides are now held every Saturday afternoon and Wednesday evening, and new men are invited to join. For destination and times of starting, see colonnade notice board.

The Club will be pleased to learn that the members of the Staff who attended the Club supper—Dr. Washbourn, Mr. Dunn, Mr. Targett, and Mr. Tubby—have each consented to accept office as Vice-Presidents, the Chairman, Mr. Golding-Bird, having again accepted the Presidency.

Members can obtain the list of officers, rides, and rules, combined with Letts' eighteenpenny Cyclist Diary and Guide, from the Secretary, at sixpence each, and intending purchasers of machines may also obtain from him the address of the agent, who allows the Club the special discount of 27 per cent., and 2½ per cent. off "The Rudge," "The Trent," "Starly Bros.," and several other high class machines.

R. TILBURY BROWN, Hon. Sec.

Tooth Powders.

By Wm. A. Maggs, L.R.C.P., M.R.C.S., L.D.S. Eng.

A tooth powder for ordinary cleansing purposes should be impalpable, innocuous, alkaline, antiseptic, and not unpleasant.

If the gums are in a catarrhal or inflamed condition an astringent should be added; and if the teeth have been much neglected, it is advisable to recommend for a limited period a powder containing very finely powdered cuttle-fish or pumice stone.

As regards antiseptics, although it is difficult to sterilize the mouth completely, still many of the antiseptics in use being non-poisonous and pleasant, they should not be omitted.

A large number of substances are recommended for dentifrices, and they include the following * ingredients, classified according to their actions:—

Alkaline.	Antiseptic.
Precipitated Chalk.	Oil of Eucalyptus.
Prepared Chalk	Carbolic Acid.
Soap.	Creosote.

Odorous and Antiseptic.	Astringent.
Oil of *Cassia.*	Rhatany Root.
„ Cinnamon.	Tannic Acid.
„ Cloves.	Alum.
„ Lavender.	Myrrh.
„ Peppermint.	Cinchona Bark.
„ *Wintergreen.*	Borax.
Otto of Roses.	Boric Acid.
	Chlorate of Potassium.

Gritty Properties.	Of Doubtful, Inert, or Pernicious, Value.
Pumice Stone.	Camphor.
Cuttle-fish.	Charcoal.
(Consists mainly of)	Sulphate of Quinine.
Calcium carbonate.	Acid Tartrate of Potassium
	Carbonate of Magnesium.
	Colouring matters.
	(e.g., *Carmine.*)
	Rose Pink.

The following prescription is useful for all ordinary purposes:—

℞ Calcii Carbonatis Precipitatœ ... ʒiij.
Pulveris Saponis Duri ... ... ʒss.
Acidi Carbolici, *vel.* ... ...
Olei Eucalypti ... ... ɱxx.
„ Menthæ Piperitæ ... ... ɱx.
„ *Gaultheriœ* ... ... ɱv. Misce.

Precipitated chalk being alkaline, cleansing, and slightly astringent, should form the bulk of a tooth powder.

Prepared chalk may be substituted for it, but the precipitated is perhaps preferable, because it is less heavy, and not so liable to cake.

* Those printed in italics are non-official.

The cleansing power of soap is too well known to need any comment. Dittmar explains its action to "the inherent property of its solution to emulsionize fats."

As antiseptics, oil of eucalyptus, carbolic acid, or creosote are best in the mouth. Perchloride of mercury must be used with considerable care on account of its poisonous properties.

Other essential oils may be ordered instead of those given, or, in addition, if it is desired to make the powder more pleasant, but this is a detail which does not affect its utility, and may be well left to the discretion of the practitioner. *Powdered orris root* may likewise be added for the sake of its odour.

For an astringent tooth powder the above formula may be given, together with "pulvis kramæriæ ʒss." Rhatany root is a powerful astringent, but tannic acid, powdered myrrh, alum, Cinchona bark, borax, boric acid, or chlorate of potassium may be substituted for it in a like proportion.

In spongy and irritable states of the gums it is advisable to prescribe a mouth wash, in addition to an astringent tooth powder.

The astringent properties of myrrh are slight, and instead of the old-fashioned *tincture of myrrh and borax*, it is preferable to order a saturated solution of tannic acid in rectified spirit; or borax, boric acid or alum in glycerine, with or without tincture of rhatany. Or a saturated solution of chlorate of potassium.

If a gritty substance is indicated, "*pulvis pumicis* ʒss.," or "*pulvis ossis sepiæ* ʒss." may be added. The constant use of such a powder is to be deprecated, as it causes abrasion of the tooth surface.

Those ingredients classed as inert, of doubtful or pernicious value, should not be prescribed for the following reasons:—

Camphor. This substance is said to cause pitting of the enamel. I am not able to substantiate this statement from personal observation, but I consider it safer to exclude its use.

Wood Charcoal. Its antiseptic properties are more than counterbalanced by its colour, and the gritty particles which it frequently contains. Furthermore, it is liable to get under the free edge of the gum, and to produce a dark line simulating that of lead poisoning.

Sulphate of quinine is feebly antiseptic and not astringent. The astringent qualities are alone found in Cinchona bark, which is also antiseptic.

Acid tartrate of potassium is contra-indicated on account of its reaction.

Heavy carbonate of magnesium is chiefly used for its antacid action.

Colouring matters are superfluous.

In conclusion, it should be stated that the mechanical cleansing of the teeth is the chief consideration, and that tooth brushes should be frequently renewed, as they soon become septic.

Passim.

We are glad to be able to state that through the munificence of the Salters' Company five beds have been endowed at the Hospital. This act of liberality is to commemorate the celebration of the five hundredth year of the corporate existence of the Company.

The East London Hospital for Women and Children was able to raise £10,000 at its dinner, and the management are to be heartily congratulated on the success of their endeavours. Could not Guy's hope for a proportionate success from a like scheme? After all, the British public likes being asked, and does not in the least respect the feeling of pride which prevents many of the older institutions from applying for help.

The new arrangements for study at the small-pox ships will be welcome to all Students, and it will be generally felt that we are now within measurable distance of being able to say that London men have adequate opportunities for the study of infectious diseases. The terms for residence at the ships are extremely moderate—twelve shillings a week only, for board, residence, and washing. The fee for a fortnight's course of instruction is but two guineas, so that no great demand will be made upon the pockets of those wishing to take advantage of these fresh opportunities for attaining to perfection.

Drs. Perry, Washbourn, and H. Davy, have been elected Fellows of the Royal College of Physicians. All the physicians on the Guy's Staff are now Fellows.

We understand that several changes are to take place in the *personnel* of the management of the Clubs' Union and Students' Club. We shall be able to specify their nature more particularly in our next issue.

It was painful to read of Professor Weissmann lecturing to badly-filled benches at Oxford, and still worse to know that many of his audience thought fit to leave in the middle of his address. Some explanation of the matter may be found in an article in the *Contemporary Review*, entitled "Practical Oxford," where it is frankly confessed that the present intellectual point of view at the University is that of "small profits and quick returns." The bearings of Weissmann's work are somewhat too remote to fit in with such practicality as this.

The first meeting of the new Dental Society clearly showed how strongly its formation had been desired by the Dental Students, over sixty of whom were present. They abundantly demonstrated the necessity for a separate society for the adequate consideration of Dental subjects, which appeared to us to be enveloped in too intricate a mystery for general discussion. We congratulate the Society on the possession of a most energetic hon. secretary in Mr. W. R. Wood (to whom its successful organisation has been very largely due) and we sincerely hope that it may enjoy a vigorous and useful future.

An old gentleman, who was some time ago in the wards as a patient under Mr. Golding-Bird, and who was very familar with the Hospital in his youth, has supplied us with many graphic sketches of individuals who frequented Guy's in those days. Of these we hope to make use on some future occasion. Meanwhile, we should like to refer here to a statement which we cannot say we believe, but to which he adhered with some dogmatism. It was to the effect that Joseph Towne was by no means the sole producer of the wax models in the museums; but

that a certain Italian named Francis did a large share of the work, though he never obtained credit for it. Our informant asserts that the fact was well known to the servants who were about the place at the time. It is most likely that the Italian's work consisted of the preparation of materials, or something of that sort, but it would be interesting to know if anyone else ever heard of this Francis.

A lady is now acting as artist to the Hospital, we believe with conspicuous success. Another lady has been appointed as clerk to the Dental Department, and holds there a very responsible position. Are we not in the van?

Our opening match with Beckenham ended unfortunately for us, but that is no reason why it should not have been reported. We sincerely hope that the cricket secretaries will see that we get reports of the matches regularly during the coming season, otherwise much disappointment will be felt by many of our readers. It is obviously impossible for us to send representatives to report all the athletic events which occur in connection with the Hospital, much as we should like to do so.

The Inter-Hospital Cycling Association holds its first meeting to-day. We trust the run will prove a great success, and that Guy's will provide a large contingent. The meet takes place at the Examination Hall on the Embankment, and the destination is Banstead.

Now that the Gull Studentship is shortly to become vacant it is well that our readers should remember how admirable are the conditions under which the student works, and how very desirable the appointment is to anyone who is able and willing to devote three years to research. Throughout his tenure he is able to obtain the very best advice and the fullest assistance, and yet he works with fewer trammels than perhaps any other endowed student in Europe. To have a free hand and yet be able to look for help when needed, is a combination of blessings which the investigator can seldom obtain. The length of tenure is sufficient for him to get over the period of breaking ground, and to produce solid results; while the endowment is large enough to make him independent, for the time being, of other calls upon his time. All this should be in the minds of those who are hesitating about applying.

Proposed United Hospitals Golf Club.

During the last few weeks the Golfers at Guy's have met incidentally and discussed the possibility of forming a club as above. When once the idea had taken root, it was found, greatly to the surprise of some, that there were at least forty enthusiastic votaries of the game in our Hospital. At first the suggestion was to hire a course once or twice a year, so that competitions might take place between the different hospitals, but as the numbers grew it was thought that an United Hospitals Golf Club might be started with a ground of their own. Guy's is, as usual, to the front in starting the movement, but no doubt is felt that the other hospitals will join in, and make the venture a success. A meeting, to talk the matter over, was held in the long room on the 7th inst., with Mr. Symonds in the chair. About twenty men were present. Mr. Tubby, in an able speech, explained the objects of the meeting. He estimated that about £150 would be required to start the movement, but thought that there would be no difficulty in raising this amount if the other hospitals gave it their support. He also pointed out that most of the golfers were already members of other clubs, so that the subscription must be low, otherwise they would probably not join, and finished up by proposing that a committee of the following gentlemen:—Mr. Symonds, Mr. Purves, Mr. Tubby, Dr. Fawcett, Mr. Scott, Mr. Henderson, Mr. Lowe, Mr. Palmer, Mr. Duncan, Mr. Coventry—be appointed to enquire into the possibility of forming the club, the amount of support such a proposal may receive from the staff and students of other hospitals, and the possibility of acquiring the ground. This was seconded by Mr. Symonds, and carried unanimously. Mr. E. N. Scott was appointed secretary *pro tem.* Mr. Purves was, unfortunately, unable to attend, but promised his support.

A Case for Diagnosis.

Kate R., æt. 10 years, came on March 6th complaining of foul discharge from ear and deafness. The membrana tympani was intact on the right side, indistinct on left. No perforations were to be seen. She was Politzerised and antiseptic drops given and ears syringed daily.

On April 17th she complained of left ear ache, and both membrana tympani were red and bulging. Her temperature was 102.

20th. Temperature 102·2. Vomiting. Constipation. Furred tongue. A few ronchi in lungs.

21st. Severe left ear ache, which ceased suddenly, and mucus was seen in meatus. Temperature 102·2.

23rd. Very severe pain in left ear. Œdema over mastoid and swelling above ear in temporal region. An incision was made down to the mastoid, and about ʒiii of foul pus and caseous material evacuated. Chloroform was given, but in small quantity, owing to there being loud râles in chest. Dressed with iodoform. In the evening (seven to eight hours after operation) she became severely convulsed. The whole body involved. She bit her tongue, and was quite unconscious. Temperature 102. No special part involved in the convulsions; but afterwards, when she complained of still severe pain in ear, it was noticed that the left arm and leg were moved and the right used very little.

24th. Temperature normal; pulse 90. Pain gone. Very little discharge from wound, and very foul smell. She won't allow her head to be touched, and shrieks out on attempting to touch it or dress the wound.

25th. Temperature normal; pulse 120. Pain returned.

27th. Much worse. Temperature normal; weak pulse. Lies on back in a semi-conscious condition. Breathing normal. Keeps putting hand to left ear and picking at it. Pupils equal and rather dilated. Eyes occasionally twitch towards left side. No paralysis or loss of sensation anywhere. Keeps saying, "Oh my poor head," and asking for her father. Was delirious in night. Died quietly early on April 28th.

Post-mortem.—A trephine opening made over mastoid and one in temporal region. The whole was explored with the finger. No pus found on left side either in bone, between dura-mater and bone, or in the brain. The lateral sinus was full of fluid blood.

What was the cause of death?

Overheard.

Smart little Boy in Medical Ward, as an Assistant Surgeon enters with his acolytes: "Look, Billy, 'ere comes the 'ead dresser, I told yer that was wot 'e was."

Old Lady at the Out-patients; Nurse has orders to show her in to the Assistant-Physician: "No indeed! I'm not going in there, my paper's marked H. P.—'ead Physician—and I mean to see 'im!"

Immunity.

A Paper read before the Physical Society, March 3rd, 1894, by Mr. E. A. Peters.

(Continued.)

There is a very interesting series of experiments on the resistance of various tissues to tubercle (Wyssokovitch). 8–40 tubercle bacilli were injected into the subcutaneous tissues, no tuberculosis followed. 20–30 injected into the veins produced tuberculosis.

Gebhardt diluted a culture with eight parts of water; this injected into the alimentary canal produced no effect. While, on the other hand, the same diluted 10,000 times and inoculated produced tuberculosis in rabbits. Thus we see that in a rabbit the intestinal tract is more resistant than lymph spaces, while, again, lymph is more immune than venous blood. Unfortunately there are no experiments to prove the relative susceptibility of the lungs, still by inhalation rabbits are readily affected.

The tissue fluids, according to Buchner, have the principal influence in effecting immunity; but experiments with tubercle have not been made.

The tubercle bacilli are not readily killed; they pass through the stomach, especially when food is contained in that organ, on account of the resistance of their cellulose coat and spores. Boiling for twenty minutes is also necessary to kill them. In the human body, where their sphere of action is limited, as in chronic phthisis, the tubercle first appear in small cells, often epitheloid cells; they are surrounded by an inflammatory area; later a reticular of cells is formed. While a large multi-nucleated giant cell is found in the more chronic form. In the ox the giant cell is full of bacilli, but in man they are not to be demonstrated. Several of the smaller cells contain bacilli. The giant cell acts as a phagocyte, but it is doubtful if the bacilli are destroyed in the process. In caseous tubercles the bacilli stand out alive in the centre of the nodule.

A glycerine extract of tubercle bacilli (Tuberculin) was injected by Koch into animals which he had previously inoculated with virulent tubercle. The bacilli were destroyed. In man, however, injection of tuberculin merely causes a rise of temperature and a local exacerbation of inflammation, without affecting the bacilli. The use of its injections in diagnosis is also contra-indicated by its occasional failures.

Tubercle cultures in glycerine, again, are extremely virulent; subcultures are less virulent, while they do not produce even diminished susceptibility of animals to inoculation.

The contagious nature of tubercle is illustrated by the imparting of the disease by a phthisical wife to her husband, besides a phthisical midwife has been known to infect several children.

The very general distribution of tubercle has been described—how it affects children, often fatally, in their

food, how in adults the respiratory apparatus is continually exposed to the bacilli in towns. A local affection of the lungs is common in adults compared to the general blood infection of children. Tubercle, especially in towns or places where its distribution and malignancy are increased, is very common. Again, from its continual presence, it must be one of the factors which mould the tissues in their action towards microphytes and the whole organism in its action and reaction or surroundings. Berry Haycraft, in his recent address, ascribed great use to tubercle in removing the weakly and weedy from mankind. Powerful factor it is, but this alone is rather an ethical question, and we will pass on to summarise its effect on individuals.

Healthy adults are free from tubercle in the ordinary contagious way, but organs becoming pretuberculous and exposed to tubercle, are liable to infection.

The disease in adults is usually local, though general infection of the blood may result from caseous glands or depression changes. Compared with that of children the blood of adults possesses considerable immunity, though how far this depends on the power of the tissues to localise the bacilli is doubtful.

Children, in addition to the increased exposure by means of food, are more open to a blood infection.

Early local disease can be cured by general therapeutics, but no bacteriological method is known at present.

Ulcerative endocarditis.—This disease, which often complicates acute diseases and acute exanthemata in which microphytes or suppuration are present, depends on the deposit of micro-organisms on the fibrinous vegetations of the heart valves.

This disease is not the specific effect of a single organism, for a very considerable number of micro-organisms may be present. In the cases of heart disease, on which malignant endocarditis supervenes, I would suggest that the micro-organisms enter by means of a damaged organ, *i.e.*, through infarcts in the lung. It is quite possible, from the analogy of pretubercular conditions, and the common distribution of the micro-organisms found in malignant endocarditis. Again, it is a singular fact that these microphytes, which occur with greatest frequency in abscesses (see Karlinski's tables) roughly appear in the same order of frequency in cases of malignant endocarditis.

1. Staphylococcus pyogenes aureus.
2. " " " albus.
3. Streptococcus pyogenes.

If this is the case, precautions as to the clean condition of the mouth and air passages, as also of inspired air, might be of service from the prophylactic point of view.

Erysipelas.—The disease, due to streptococcus erysipelatosus, and closely resembling in appearance streptococcus pyogenes, which is found in pus, loses its virulent power very readily if subjected to subculture in rabbits. After a few passages it merely produces a twenty-four hours' flush on injection. This is all inoculation of streptococcus pyogenes produces. However, authorities are certain of the difference of the two organisms, and do not consider there is a change of function.

Fehleisen has produced the disease in men by inoculation, and undertakes to remove sarcomata. This removal has been successful. Medical erysipelas is supposed to enter by means of respiratory passages.

Septicæmia is due to many germs, and most animals have a special malignant form to which they are liable. In man staphylococcus liquescens albus, S. liquescens aureus and certain streptococci are the commonest causes. They show the most virulent form which microphyte disease takes.

The classical symptoms are œdema at the seat of inoculation—the microphyte is in the blood in very large quantities, usually causing infarcts in the spleen and kidney—general congestion of the organs with ecchymoses of serous membranes.

Cloudy swelling or fatty change of the uriniferous tubules and of the liver is common. These and all other effects are due, as a rule, to the toxins formed in some way by metabolism as the result of the microphyte.

In these acute cases there is no phagocytosis, due, according to the phagocyte theory, to paralysis and death of the phagocytal cells by the toxin, and to lack of chemiotaxis. According to the "tissue-fluid theory," on the inefficiency of tissue substances.

In the case of septicæmia of the guinea-pig, Woolridge grew the microphytes on an alkaline medium and found that the virulence diminished.

Charbon Symptomatique (or "blackleg") affects young cattle and sheep, and is very fatal. It consists of a large œdematous swelling, which causes gangrene, with the formation of gas; a property which malignant œdema shares with it. It is fatal in two or three days. Immunity is attained in two ways.

1. In the guinea-pig a drop of the fluid from the vesical is injected in only very small quantity. The animals are then refractory to a large injection.
2. Two vaccines are prepared. The fluid is extracted from the œdematous swelling and dried at 32° C.

The material for the first vaccine is heated to 100° F., that for the second and more powerful to 86° F. Animals thus treated are refractory to the disease.

Anthrax.—Infection from the bacillus is very common in animals. An animal affected conveys the microphytes in all its discharges, with which its feeding ground becomes infected. Anthrax is ectogenic, *i.e.*, can live apart from an animal. In France some pastures are quite saturated with this virus, and it is certain death for an animal unprotected against this organism to feed there.

The bodies themselves, if unopened, are not a great source of infection, for anthrax is anærobic and degeneration of the bacilli takes place in forty-eight hours in the bodies dead of the disease. Man is affected either from an animal, which is rare, or more frequently from the dust of hides removed from the poisoned bodies.

The forms of disease in men are—

1. Lung form.
2. Intestinal (mycosis intestinalis).

Both are septicæmic.

3. *Local inoculation forms malignant pustules.*

In the last the disease occasionally becomes septicæmic, but the usual course is recovery, under surgical treatment, the infection being strictly local.

But death may occur from the poisonous products of the bacilli. Anthrax, recent or remote, becomes less virulent after growth on alkaline agar for some weeks. This form is also less resistant to $HgCl_2$. Hueppe has suggested that a non-pathogenic variety may exist in the ground, but there is no proof of this, however.

We have a very full list of methods by which the virus may be attenuated; and the attenuated virus protects. The attenuation is transmitted to generations of culture.

1. Heat up to 50° C. (Toussaint). 2. Exposure to 5 per cent. carbolic (Chauvain. 3. Pasteur has used vaccination for the treatment of cattle living in the anthrax pastures.

1st. Vaccine prepared by keeping a chicken-broth culture at 42° for fourteen days.

2nd. Vaccine—a chicken-broth culture is exposed in the same way for a week.

Pasteur has used these vaccines in series very successfully. However, its use in England has not been successful in many cases. For some reason unknown, it does permit of protection to animals fed on anthrax spores (Klein).

The other methods for attaining attenuation are:—4. Injection of the blood of a mouse poisoned with anthrax. 5. Injection of anthrax obtained from a guinea-pig treated with $HgCl_2$ (1—25,000). 6. Woolridge found in a culture of anthrax in alkaline albumen, chemical substances which conferred immunity on rabbits.

Hankin showed that this was an albumose. Martin very carefully isolated the substances formed in an albumin culture, and found that very similar changes to those of tryptic digestion took place. Albumoses, ultimate products, bile, leucin and tyrosin were present. Proto and dentero albumoses were present together, with an alkaloidal base. These substances were separated and injected into rabbits.

The alkaloid caused deep coma, and apparently is the more usual cause of death. The albumose when injected brought about a great rise of temperature. The albumose heated previously to injection loses its power. There is probably some body of the nature of a ferment present with it. Thus the dentero albumose and alkaloidal base are the cause of death in the septicæmic and localised form of disease, while they account for the fatal neuritis which sometimes occurs. Phagocytosis is very marked in the local form of the disease, *i.e.*, injection of the virus causes concomitantly with the œdema a great increase of leucocytes and mesoblastic cells. These latter, divided into macrophages and microphages, are attracted to the bacteria and envelope them, certainly in the living state, as also in the dead. Whether recovery depends on this action of phagocytes, or phagocytosis is merely secondary to the action of the tissue proteids will be considered later. The immunity with regard to anthrax is natural or artificial. *Naturally immune animals are frogs*, Algerian sheep (which are immune against most micro-organisms) white rats. The immunity in several of these animals depends on the amount of anthrax injected.

Wild rats are immune; while with mice, anthrax takes the form of acute septicæmia; young rats are, however, readily affected by the disease, and so are rats fed on bread diet (Hankin).

We have seen that immunity is conferred on animals by the injection of attenuated virus, though it is doubtful if it is absolute against formidable doses of the poison, or if it is lasting; further, the attenuated virus is anthrax with charged physiological properties. The immunity conferred is really by a means of vaccination, the animal suffering from a mild form of the disease. Whether this is produced by a physiological change in the phagocytes, or by an antitoxin produced either by means of phagocyte, leucocyte, or plasma change is doubtful.

Pneumonias are, as a rule, localised septic processes, due in the typical cases of the croupous affection of one lung to the pneumococcus of Fränkel and Weichselbaum, but in mixed cases either to local affection from septic material finding its way from the mouth, nose, or suspended in air, down the respiratory passages; or the organisms may be blood carried (pyæmia, etc.).

The typical form of the disease caused by the pneumococcus of Fränkel will be considered later.

Miller has found in the mouths of Germans no less than twenty pathogenic organisms, a large number of which cause septicæmia in animals. The bronchial membrane *in health is practically free from organisms (Hildehardt)*, the upper air passages acting very efficiently as filters. With their entry into the lungs broncho-pneumonia is set up.

The septic pneumonia occurring after wounds or ulcers of the air passages show a very large number of organisms, and is to be compared to suppuration in any part of the body. Damage or any lessened resistance of the lungs probably accounts for these. Under this heading come the septic broncho-pneumonias.

Closely allied to these are pneumonias apparently of a mixed type, both lungs being affected, but the disease is due to one kind of organism.

The pneumonias described by—

1. Klein. This is common after influenza, and is due to a short bacillus.
2. Foa.
3. Mosler.
4. Freidlander.
5. Streptococci are undoubtedly the cause of a pneumonia of this kind.
6. Lastly, fibrinous pneumonia, due to the pneumococci, of Fränkel and Werchselbaum, which have been found in the buccal cavity (Miller); though it must be very rare according to most observers.

Finkler divides pneumonias into three classes:—

1. Croupous pneumonia with fibrinous exudation.
2. Broncho pneumonias due to numerous organisms.
3. Cellular pneumonia due to a streptococcus.

The disease due to the pneumococcus is prominent of them all. In animals the inoculation causes septicæmia, particularly in mice and rabbits.

In man, besides the localised form, the pneumococci not infrequently are distributed in the blood, and set up suppurative meningitis and empyemata. It is also found in malignant endocarditis and in the discharge from otitis media.

Emmerich and Fawitsky's experiments on immunity from the pneumococcus are very interesting.

They first attenuated pneumococci and injected them into rabbits. These became immune to ordinary fatal injections of virulent pneumococci. The tissue juices of this animal were extracted by pressure, and their effect with regard to immunity estimated by injecting first virulent pneumococci into a rabbit, and then the tissue fluid of the first rabbit. Slight immunity followed, or rather the animal died a short time after the control rabbit.

In a second series of experiments immunity was acquired by giving small, very diluted doses of a virulent culture; a culture was diluted with twenty-five parts of distilled water. This animal was found to be immune. Later it was killed, and its tissue fluids were used, and were found to confer immunity on other rabbits from diplococcus injection.

This seems to point out that a species of vaccination in the case of pneumonia does not bring about such powerful changes as inoculation with a minute diluted quantity of virulent culture.

Immunisation by small doses of the virulent material throws light on general infection.

In the exanthemata the neighbourhood of a patient is infectious on account, apparently, of the virus given off by his body. The probability of a susceptible person being affected depends on the dilution, or how far off he is from the infected body; in the case of typhus three feet is said to be a dangerous limit. It was long ago said that this was due to dilution or oxidation of the poison. On the other hand, much infection is due to the concentrated poison met with in scarlet fever scales. Dilution is probably the factor. And, further, we have some suggestion that some immunity is actually conferred by the minute doses of poison which nurses in scarlet fever hospitals must be continually receiving. I have been informed by a superintendent of one of the London fever hospitals that, as a rule, a nurse takes scarlet either during her first few weeks at the hospital, or on her return to the hospital after a holiday. Infection, when out of health, being comparatively rare to that acquired under these conditions.

Of influenza little can be said. But now that after several reported discoveries the pathogenic germ is said to be that described by Pfeiffer, and separately by Kitasato, as a streptococcus, more advance may be expected.

With regard to immunity after a previous attack, this is slightly present, according to Althaus.

Diphtheria is a localised bacillus infection of the palate and tonsils, which may, however, spread down into the lungs or down the œsophagus, or up into the nasal passage. It forms a membrane which consists of the necrosed mucous membrane, in which are embedded septic organisms, while deeper down in the tissue, or in small clumps in the membrane, are found the specific bacillus diphtheriticus. The organism is quite localised; in most fatal cases, death is due to the products of the metabolism of the bacilli. Roux and Yusin showed that a culture in veal, freed of the bacilli, yielded a poison of the nature of a diastase; ·0004 grain of this poison was fatal to two rabbits. Sydney Martin, working on bodies dead of diphtheria, extracted from the tissues and spleen a dextero albumose, and an organic acid. Injection of the albumose into animals caused high fever, and after several doses paralysis—frequently appearing after two days—diarrhœa (especially with large doses), general wasting, and slow coagulability of the blood.

The nerves of a motor character presented degeneration of the white substance of Schwann and frequently rupture of the axis cylinder below this. Degeneration of this kind either stretched across the nerve or involved a few fibres. Wallerian degeneration was present below these points. The sensory nerves are characterized by nodular degeneration, while the sympathetic are deeply affected. Paralysis frequently is not noticed, even after degeneration has set in.

(To be continued.)

Calendar of Coming Events.

May 12th.—1st XI. v. Surbiton, at Honor Oak Park.
United Hospitals' Cycling Association. Opening. Run to Epsom and Banstead. Start 2.30 p.m. from Examination Hall.
" 14th.—Whit Monday. Medical Office closed.
" 15th.—Guy's Hospital Rifle Association v. Charing Cross, at Ilford.
" 17th.—Guy's Hospital Christian Union. General Meeting at 4.30 to consider the means by which we may best advance Missionary Work. Dr. J. J. Coleman in the Chair.
" 18th and 19th.—1st XI. v. Repton School, at Repton.
" 19th.—2nd XI. v. Croydon, at Honor Oak Park.
" 21st.—Final Fellowship Examination begins.
" 22nd.—Cambridge Second M.B. Schedules to be brought to Medical Office for signature.
Guy's Hospital Rifle Association v. St. Mary's, at Ilford.
" 23rd.—1st XI. v. Bickley Park, at Bickley Park.
" 24th.—Guy's Hospital Christian Union. Weekly Address. Captain Orde-Browne, "In Understanding be Men."
" 26th.—1st XI. v. Mitcham, at Honor Oak Park.
2nd XI. v. Dulwich College, at Dulwich.

Pathological Poesy.

We enquired in our last for a Poet, and he has arrived. Now, it is our ambition to move with the times, and we would therefore be occasionally found even among the *décadents*. But it is very difficult to know precisely when an editor misses a chance of being décadent, and we therefore publish some of the new poet's verses here, lest hereafter a reproach come against us that we failed to appreciate our opportunities.

It is an "Ode to the Heart" that he sends us; and his muse at once asserts her strength with two lines of incontrovertible Truth, followed by two more of most incontestable originality.

"ODE TO THE HEART."

The heart is a pump, but it is different
From the antiquated village instrument;
The former is essentially vital,
The later extremely mechanical.

This being so (and who will be found to deny it?), our poet goes on—

Of other differences there are many,
Needless they are to describe,
For they are perfectly obvious to any
Who study the human tribe.

I have chosen the vital machine
To be the subject for my theme;
'Tis of the diseases I would treat
Which pick it out for their seat.

To begin with the lining membrane,
I must tell you of Endocarditis;
But for a cure you will search in vain
As you would for Acute Meningitis.

The causes you need not fear,
They are Rheumatism and Chorea;
'Tis the results, which you will dread
They may keep your patient in bed.

Then we have a full account of the steps which lead up to this dire catastrophe of bed, and

Dreadful is then the result you know,
For the legs and abdomen may grow;
Apparently they become very fat
But really you know it's not that.

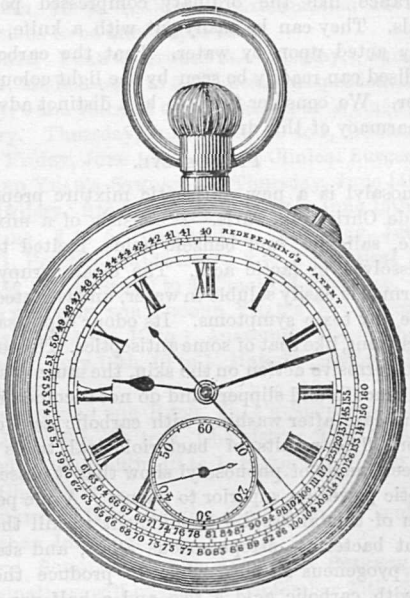
Backward pressure from venous congestion
Throws strain upon capillaries;
As a result you get exudation,
Into tissues subcutaneous.

Some people call it water-logging,
Dropsy is a term worth knowing;
Œdema is mentioned by some,
This may also apply to the lung.

It is sometimes the good fortune of our Gazette Poets to get translated. We should like very much to see the above in French; or at any rate to see the author translated in some way.

Notices.

We have had handed to us for inspection a watch bearing a new and ingenious device for registering the pulse-rate quickly and accurately. The new pulsimeter is the invention of Mr. Redepenning, of 11, North Crescent, Bedford Square, W.C. The accompanying illustration of the watch is the same as appeared in the *Lancet* of a week or so ago.



The directions for use are as follows:—

To find the rate of the pulse per minute, press the keyless knob with the finger of one hand, thus starting the chronograph hand, while with the fingers of the other hand on the pulse, mentally counting the arterial beats. When twenty beats have been counted, again press the keyless button, and the figure at which the chronograph hand stops indicates the pulse-rate per minute. A third pressure of the button will bring the needle back to its starting place at the XII, and until this is made the watch will be registering the pulse-rate that was last taken. The advantages claimed for the device are:—

1. The pulse-rate per minute can be accurately obtained in the brief space of ten to fifteen seconds.
2. The number of pulsations can be counted without looking at the watch, and without the patient's knowledge.
3. The pulse-rate can be taken in the dark.
4. It can be taken without removing the watch from the pocket, and so registered for after reference.
5. It is a strong, serviceable watch, with good movement, and a reliable timekeeper.
6. The cost is about the same as an ordinary watch in silver or gold.

BLAUD'S PILLS JELLOIDS.

Messrs. Warwick Brothers, Manufacturing Chemists, 18, Old Swan Lane, London, E.C., have lately introduced a new form of administration of ferrous carbonate. This consists of a jujube mass, in which the freshly precipitated carbonate is incorporated. The salt is perfectly protected from the action of the air, and remains in that particular state, which is considered to be the most easily assimilable. The jelloids are in appearance like the ordinary compressed pellets or tabloids. They can be easily cut with a knife, and are quickly acted upon by water. That the carbonate is unoxidised can readily be seen by the light colour of the interior. We consider them to be a distinct advance in the pharmacy of this drug.

PHENOSALYL.

Phenosalyl is a new antiseptic mixture prepared by Dr. J. de Christmas, Paris. It consists of a mixture of carbolic, salicylic, and benzoic acids, melted together and dissolved in lactic acid. The clear syrupy liquid thus formed is easily soluble in water, and is stated not to produce any toxic symptoms. Its odour is pleasant, but not persistent, like that of some antiseptics. The solutions have no corrosive action on the skin, the mucous surfaces remain smooth and slippery and do not become dried up, as is the case after washing with carbolic acid or hyd. perchlor. The results of bacteriological trials which have been made of phenosalyl show that it possesses an antiseptic power far superior to phenol. A one per cent. solution of this antiseptic is sufficient to kill the most resistant bacteria — streptococcus albus, and staphylococcus pyogeneus aureus—while to produce the same effect with carbolic acid a two and a half per cent. is required, and the exposure or contact continued for a longer period. Phenosalyl has been used for the sterilisation of surgical instruments, of gauze, and of different organic substances like blood, saliva of consumptives, and decomposing urine, with apparently excellent results.

Phenosalyl can be obtained from Messrs. Burroughs, Wellcome & Co., Snow Hill Buildings, London, E.C.

Students' Club General Meeting.

THE Annual General Meeting of the Students' Club was held on the 3rd inst., in the Anatomical Theatre. There was a considerable attendance of students, all in varying stages of inanition, with the exception of a few choice spirits in the gallery, who beguiled the time by physical exercises of an unscientific order. The contrast between this meeting and that of November last was very marked, but votes of censure are more attractive at all times than the transaction of ordinary business. Mr. Durham, as chairman, gave some interesting reminiscences, and demonstrated how students in the old days suffered from the lack of those facilities for rest, recreation, and refreshment, which were now afforded by the Club. He also indicated several improvements and reforms which were being effected. The meeting then proceeded to consent to certain alterations in the rules, which Mr. Fripp, as hon. secretary, somewhat quaintly described as being "very little more than an alteration in principle." The voting for three representatives of non-resident members to serve on the Committee, resulted in the return of Messrs. H. J. Spon, H. T. Bell and B. G. Reynolds, in order named.

The election over, Mr. Durham informed the meeting that if any one had complaints to make or suggestions to offer, now was their time. Here the figure of Hoare came in view, bearing a handsome silver candelabra, and four silver candlesticks, which he placed on the table before Mr. Durham, whose bland smile instantly gave place to a look of complete bewilderment. Mr. Luce, in a few well-chosen remarks, explained the situation to him, and asked his acceptance of the silver as a token of affection and regard from the Students of Guy's Hospital Hereupon the audience woke up and gave Mr. Durham an ovation which pretty effectually proved the good will which went with their parting gift, and when silence was restored Mr. Durham said: "My dear boys, I thank you most heartily."

Guy's Hospital Dental Society.

THE first meeting of this Society was held on Tuesday, May 8th, at five p.m., in the theatre attached to the dental conservation room, which had been tastefully decorated for the occasion. There was a large attendance.

The president, Mr. Newland-Pedley, delivered his inaugural address, in the course of which he thanked the Presidents of the Physical Society for the facilities they had given for the discussion of dental subjects. It was at a meeting of the Physical Society that the pressing need of the new society first manifested itself, for dental students had shown themselves quite unable to conduct a professional discussion. He dwelt upon the importance of acquiring facility in the art of speaking; and he hoped that every student present would exercise a worthy influence upon his profession, so that dentistry might take up its true position as one of the highest and most honourable specialities in surgery.

Mr. C. H. Craal then read an excellent paper on "The Treatment of Temporary Teeth." We understand that it will be reported at full length in the "Transactions," which will be published shortly.

An animated discussion followed, in which the President, Mr. Richards, and Messrs. Walter Wood, J. W. Pare, R. D. Evans, G. Willcox-Jones, H. Wallis, J. B. Parfitt and W. H. Fletcher took part.

The usual votes of thanks terminated the proceedings

Pass List.

Final Conjoint Examination, April, 1894.

MEDICINE, SURGERY AND MIDWIFERY.

* Hardenberg, E. F. H.

MEDICINE AND SURGERY.

* Annis, E. G. * Cowan, F.

MEDICINE AND MIDWIFERY.

Zumbado, F.

SURGERY AND MIDWIFERY.

Beach, H. W. * Cooley, A. G.
Bond, C. S. King, T. P.
Burrell, L. C. Lucas, C. R.

MEDICINE ONLY.

* Collis, A. J. Reeves, A.
* Field, G. H. * Roe, E. E. W.
* Miller, A. * Wilmot, P. McK. C.

SURGERY ONLY.

* Card, A. H. Matthews, A. K.
Collier, H. W. * Miller, W. F.
Evans, R. D. Reynolds, B. G.
Greenway, C. M. Steele, G. H.
Hinds, H. A. * Steele, W. K.
Stoner, H. B.

MIDWIFERY ONLY.

Croneen, S. * Mills, T. I.
Evison, F. A. Moon, R. H.
Hearnden, H. * Parry, L. A.
Lulham, E. P. H. * Phillips, R. E. G.

* Denotes completion of examination.

University of Cambridge, May, 1894.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART I.

Bond, C. S. Burrell, L. C.
King, T. P.

PART. II.

Collis, A. J. Hopkins, C. L.
Day, F. N. Peters, E. A.

Appointments.

GOODALL, E., M.D. Lond., B.S., M.R.C.P., M.R.C.S., has been appointed Medical Superintendent of the Joint Counties Lunatic Asylum, Carmarthen, *vice* Hearden.

THEED, WILLIAM C., M.R.C.S. Eng., has been appointed Public Vaccinator for Allansford, Victoria, Australia.

TRESIDDER, E. S., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to the Burrangong District Hospital, at Young, New South Wales.

Prize Examinations.

SUMMER SESSION.

Competition for the undermentioned Prizes will take place on the following dates :—

THE TREASURER'S MEDALS.—Wednesday, June 6th, 10 to 1, Surgery; 2 to 5, Medicine. Thursday, June 7th, 10 to 1, Commentary on a Case in Medicine; 2 to 5, Commentary on a Case in Surgery. Friday, June 8th, 10 to 1, Clinical Examination in Medicine. Saturday, June 9th, 10 to 1, Clinical Examination in Surgery. Operations to be announced later.

FOURTH YEAR'S STUDENTS.—Tuesday, June 12th, 10 to 1, Medicine; 2 to 5, Medical Jurisprudence. Wednesday, June 13th, 10 to 1, Diseases of Women; 2 to 5, Surgery. Thursday, June 14th, 10 to 1, Clinical Medicine. Friday, June 15th, 10 to 1, Clinical Surgery.

THIRD YEAR'S STUDENTS.—Thursday, June 14th, 10 to 1, Midwifery; 2 to 5, Surgery. Friday, June 15th, 10 to 1, Medicine; 2 to 5, Therapeutics. Saturday, June 16th, 10 to 1, Practical Midwifery; 2 to 5, Practical Surgery. Monday, June 18th, 2 to 5, Practical Medicine.

EXAMINATION FOR SECOND YEAR'S STUDENTS.—Wednesday, July 18th, 10 to 1, Anatomy; 2 to 5, Physiology. Thursday, July 19th, 10 to 1, Materia Medica; Practical Physiology.

EXAMINATION FOR FIRST YEAR'S STUDENTS.—Wednesday, July 18th, 10 to 1, Chemistry; 2 to 5, Anatomy. Thursday, July 19th, 10 to 1, Physiology; 2 to 5, Practical Chemistry.

GURNEY HOARE PRIZE.—Essays to be sent in not later than July 2nd.

OPEN SCHOLARSHIPS IN ARTS AND SCIENCE.—These Examinations will be held on September 25th, 26th, and 27th.

Practical Dentistry Prizes.

EXTRACTION ROOM EXAMINATION (First and Second Year's Students).—Commencing on Monday, June 4th, at 9 a.m.

CLINICAL EXAMINATION (First Year's Students).—Monday, June 11th, at 2 p.m.

CONSERVATION ROOM EXAMINATION (First and Second Year's Students).—Monday, June 18th, at 9 a.m.

CLINICAL EXAMINATION (Second Year's Students).—Monday, June 18th, at 2 p.m.

LABORATORY EXAMINATION (First and Second Year's Students).—Tuesday, June 19th, at 9 a.m.

SPECIAL CONSERVATION ROOM EXAMINATION.—Monday, June 25th, at 9 a.m.

Acknowledgments.

The Cambridge Review.
The Hospital.
The Universal Tutor.

Guy's Hospital Dental Department.

Practice during January, 1894.

Gold Fillings		312
Amalgam ,,		431
Osteo ,,		
Perm. G.P. ,,		
Temp. G.P. ,,		107
Artificial Crowns		21
Scalings		30
Dressings		107
Attendances for Mechanical Appliances		11
,, Extractions under Anæsthetics		565
,, ,, without ,,		420
Advice		31
Total		2035

Practice during February, 1894.

Gold Fillings		376
Amalgam ,,		541
Osteo ,,		
Perm. G.P. ,,		
Temp. G.P. ,,		107
Artificial Crowns		37
Scalings		35
Dressings		150
Attendances for Mechanical Appliances		15
,, Extractions under Anæsthetics		595
,, ,, without ,,		464
Advice		27
Total		2347

Practice during March, 1894.

Gold Fillings		253
Amalgam ,,		415
Osteo ,,		
Perm. G.P. ,,		
Temp. G.P. ,,		77
Artificial Crowns		50
Dentures		5
Dead Teeth		103
Scalings		29
Dressings		119
Attendances for Extractions under Anæsthetics		470
,, ,, without ,,		572
Advice		31
Total		2124

Birth.

PILKINGTON.—On April 27th, at Gower Street, W.C., the wife of F. W. Pilkington, M.D., Adlington, Lancashire, of a daughter.

Sport.

Cricket.

GUY'S HOSPITAL (2nd XI.) v. GRANVILLE (LEE) C.C.

Played at Lee on Saturday, May 5th, and won by the latter. Scores:—

Guy's.

F. C. Wetherell b Glover	4
J. Moore b H. Edwards	4
C. J. Anderson b Glover	2
H. Durbridge b H. Edwards	1
T. G. Ouston b H. Edwards	0
T. M. Walker c Glover, b Edwards	7
E. J. Spriggs lbw b J. Edward	4
T. Morgan b Glover	1
E. G. Goddard b W. Edwards	1
F. Goldie, not out	1
P. W. Moore c Furze, b J. Edward	0
Extras	10
Total	35

Granville (Lee) C.C.

F. E. Lauder b Spriggs	7
R. F. Taylor b Wetherell	5
L. R. Glover b Ouston	31
W. Edwards c J. Moore, b P. W. Moore	25
J. P. Clarkson b Ouston	0
E. Furze b J. Moore	3
W. Greer, not out	8
E. F. Debenham b Spriggs	3
J. A. Johnston b J. Moore	0
H. Edwards b J. Moore	0
J. Edward b J. Moore	0
Extras	10
Total	92

Guy's 2nd Innings.

Anderson, 20; Spriggs, 6; Goldie, 2; Morgan, not out, 2. Total, 36 for three wickets.

Marriages.

FULLER—PURVIS.—On April 19th, at St. Alphege Church, Greenwich, Courtenay James Fuller, L.R.C.P., M.R.C.S., of Rectory Place, Woolwich, to Clara Cornwall, youngest daughter of Prior Purvis, M.D. Lond., of Lansdown Place, Blackheath.

SCOTT-BROOKHOUSE.—On April 19th, at St. Thomas's Church, Nottingham, Thomas Graham Scott, M.R.C.S., L.R.C.P., of Denmark Hill, London, to Emily Hannah Halford, second surviving daughter of Joseph O. Brookhouse, M.D., M.R.C.P., of Nottingham.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

MAY 26, 1894.

Influenza.

CLINICAL LECTURE BY DR. WASHBOURN.

THE case I am bringing before you to-day, is that of a married woman, 27 years of age, who was admitted into Miriam ward, on April 5th, for pyrexia, dyspnœa, and collapse.

In the *family history* there is nothing of importance. As regards her *previous condition of health*, there is the history of attacks of bronchitis during the last four years, and of an attack of inflammation of the lungs following upon her first pregnancy, three years ago.

The *history of her present illness* is the following:—She had suffered from a slight cough for some time, but was otherwise quite well. On the evening of March 30th, six days before admission, she was suddenly seized with pain in the side and chest, and felt so ill that she could not stand, and was compelled at once to take to her bed. Since then she has suffered from cough, with much expectoration, but no hæmoptisis; she has perspired profusely, and has been delirious at night. During the last few days she has rapidly lost flesh.

Condition on admission.—She is very collapsed and is breathing rapidly and with difficulty. Her lips and finger-nails are quite blue, but the latter are not clubbed. The tongue is covered with a brown fur. The respirations are 48; the temperature 103·6; and the pulse 126, and very small and compressible, but regular.

An examination of the chest revealed the presence of loud rhonchi, and râles in all parts, and there was dulness at the right base behind. The *sputum* was scanty, thick and rather tenacious, but it contained no blood. No specimen of *urine* could be obtained.

Progress of case.—April 6th. The temperature is not so high, but the patient is much worse. The respirations are still rapid, 46 per minute, and the cyanosis is much more marked. The pulse has increased to 150 per minute, and is very weak and compressible. The patient has vomited several times.

The area of dulness at the right base has increased, and now reaches nearly to the angle of the scapula. Over the area there are loud consonating râles. The other physical signs have not altered.

Injections of strychnine were given, and oxygen was administered with much relief to the dyspnœa.

April 7th. Patient slept fairly well during the night, and is decidedly better this morning. The respirations are 40; the temperature 101; and the pulse 120. The physical signs in the chest remain. The urine was examined to-day and was found to contain a trace of albumin.

From this date the patient gradually improved, but the physical signs were a long time in clearing up.

On April 9th, a needle was inserted into the right side of the chest at the dull area. Only blood was drawn off. The blood contained no micro-organisms.

On April 11th, the signs at the right base were less marked, and there was only a faint trace of albumin in the urine.

On April 14th, the dulness had disappeared, but there were still râles in the chest behind.

On April 29th, the physical signs had disappeared, and the patient left the hospital quite well.

The *treatment* adopted was at first Digitalis combined with an expectorant, together with administration of alcohol. The medicine was soon changed for subcutaneous injections of strychnine, and the inhalation of oxygen. As the patient improved, Nux Vomica and expectorants were substituted.

Let us now look at this case from the point of view of *diagnosis*.

The salient features of the case on admission were the following: A young woman who had suffered for some years from attacks of bronchitis was suddenly seized, six days before admission, with severe pains in the chest, and felt so ill that she was compelled at once to take to her bed. From this time she was delirious at night, perspired profusely, and suffered from cough, with much expectoration. On admission, she was in a high fever, was much collapsed and cyanosed, and a physical examination of the chest revealed dulness at one base with consonating râles, and râles and rhonchi all over the rest of the chest.

We thought the diagnosis lay between the following conditions:—Tuberculosis, acute following upon chronic bronchitis; pneumonia; acute empyema; pyæmia; influenza.

Tuberculosis.—In favour of this was the previous history of lung trouble, the high fever, and the cyanosis. *Against:* the previous lung trouble did not appear to be tubercular (there had not been wasting nor hæmoptysis), the onset was sudden, the physical signs were not those commonly met with in tuberculosis of the lung.

Acute following upon chronic bronchitis.—Although the patient had suffered from attacks of bronchitis, yet there was no evidence of the results of chronic bronchitis (emphysema, dilated right heart, etc.) Again, the patient was young for an attack of such severe bronchitis, but still more important was the physical examination of the chest, which showed that there was something more than simple bronchitis.

Pyæmia.—As against this was the absence of rigors and the fact that there was no evidence of a primary seat of infection.

Acute empyema.—This was quite a possible diagnosis. The sudden onset, the pain, rapid breathing, temperature, and the physical signs at the base were all conformable with such a diagnosis. The patient was at first too ill to explore with a needle, but later this was done and no pus found.

Pneumonia.—The history and the constitutional symptoms were quite conformable with a diagnosis of croupous pneumonia. As against pneumonia was the fact that the consolidation was not complete. The typical signs of consolidation, tubular breathing, etc., were not present. More important, however, was the fact that the sputum, although tenacious, was not rusty.

Influenza.—This was the diagnosis we made, and for the following reason. The sudden onset, the pains, the prostration, and the physical signs in the lungs, all pointed to a severe attack of bronchial influenza, and having eliminated the other conditions above mentioned, the diagnosis of influenza was easy.

The recovery of the patient was remarkable. During the first two days the chance of recovery seemed to be very slight; the patient was utterly collapsed, and the pulse was 150 per minute and extremely weak. Injection of strychnine and inhalation of oxygen appeared to have greatly assisted in her recovery.

The Influenza Bacillus.

In making a diagnosis of this case we omitted, owing to press of other work, a method which might have materially assisted us in coming to a conclusion. We did not examine the sputum for the presence of the influenza bacillus.

Let me say a few words about this micro-organism.

It is a rod-shaped body, very slender (generally compared in thickness to the bacillus of mouse septicæmia), and about two or three times longer than broad. The bacilli are frequently united lengthways in pairs, and, on account of their shortness, are very easily mistaken for diplococci.

The bacillus stains with difficulty. The best method is to use a solution of carbolic fuchsin, diluted with water, and stain the cover glass for ten minutes, and afterwards to wash with water and mount in the usual way.

The bacillus can be found often in pure cultivation in the greenish yellow sputum in cases of bronchial influenza. In catarrhal cases it can also be found in the secretion from the nose, but there it is almost invariably mixed with other bacteria. Those who have worked much at the subject state that a diagnosis can generally be made from a microscopical examination of the sputum.

Cultivations are attended with some difficulty as the ordinary media are not suitable for its growth. The presence of hæmoglobin in the medium favours the growth of the bacillus. The best method to adopt is the following: Pigeon's blood is removed with aseptic precautions, from the blood vessels, and allowed to clot on the surface of sterilized agar in a test-tube, the sputum is sown upon the blood and the tube kept in an incubator at blood heat. In twenty-four hours the influenza bacilli have formed minute transparent colonies hardly visible to the naked eye.

Numerous observations have been made of the sputum in blood and other secretion in other diseases, and in no instance have bacteria been found with the characters of the influenza bacillus.

In *influenza* the bacillus is only found locally, and is not present in the blood except in rare cases. It is thus similar to the diphtheria and the tetanus bacillus.

Experiments in inoculating animals have not been successful, except in two instances in the case of monkeys.

The evidence of the influenza bacillus being the cause of the disease, rests on the fact that the bacillus is always present in the sputum of cases of bronchial influenza, and is not present under other conditions. Such evidence as this is much more conclusive now than it would have been in former years, when the bacterial origin of disease was still an open question.

The Pneumonia of Influenza.—Two conditions have to be distinguished. (1) A consolidation occurring during the primary attack of the disease, and due to the influenza bacillus. This was the condition in our case. The consolidation under these circumstances is not so complete as in croupous pneumonia, and this is what our physical signs led us to suppose.

Post-mortem examinations show that in this form of consolidation the part affected consists of areas of consolidation interspersed with areas filled with air. The influenza bacillus has been found in these consolidated portions.

(2) A croupous pneumonia occurring as a sequela to influenza. There is no difference between this condition and that of a primary croupous pneumonia, except that it is more fatal on account of the patient being weakened by the previous attack of influenza. This pneumonia is generally due to the pneumococcus (A short description of the pneumococcus was then given). The history of these cases is generally that the patient has suffered from an attack of influenza and went about his occupation directly the severe symptoms had subsided. He is then suddenly seized with the characteristic symptoms of acute pneumonia which runs its course in the usual way, but with marked severity.

Notes on Dr. Shaw's Demonstrations in Pathology.

BLADDER.

Tuberculosis.

1. Miliary (2092[55], 21024).
2. Ulcerative (2033[30], 2102[5, 6, 11, 12]).

Tubercle is brought to the bladder (*a*) by the blood vessels, in which case there is sure to be an acute tuberculosis; (*b*) by the urine in which case the disease is confined to the genito-urinary tract. Bladder may be directly infected by the vesiculæ seminales.

Growth.

1. Benign. (*a*) Polypus (2104[11]), difficult to determine the absence of malignancy, as malignant growths in bladder often take on a polypoid or villous form; if muscular coat is involved the growth is malignant. (*b*) Dermoid cyst (2104[31]). (*c*) Villous (2104[4, 7]), liable to cause fatal hæmorrhage.
2. *Malignant.* (*a*) Carcinoma (2104[6]) tends to ulcerate and often become villous. (*b*) Sarcoma (2104[20, 22]).

Hydatid (2104[57]) very rarely if ever seen in bladder, but common in the pelvis, and so become attached to the bladder.

Injury. Rupture (2104[81]). Perforation by catheter (2104[90]).

Hernia of bladder (2487).

PERICARDITIS.

Stages:—

1. Vascularity.
2. Loss of polish owing to deposition of lymph, which takes place first at the base of the heart, hence the rub is usually first heard in the aortic area.
3. Effusion of lymph (1438[50], 1441).
4. Serum or pus (1438). The effusion may be absorbed or be so excessive as to kill the patient.
5. Thickening (1446).
6. Adhesion (1437[20]). Chronic thickening or even adhesion may take place without any antecedent acute pericarditis. Adhesion of the pericardium is associated with fibroid degeneration of the heart muscle.
7. Classification (1448[50], 1448).

Common causes.—(*a*) Rheumatism (1446). (*b*) Bright's disease (1430). In rheumatism the pericarditis is generally the cause of death, hence it is found post-mortem in a very advanced condition; whereas in Bright's disease we have specimens of the earlier stages. (*c*) Pneumonia (1438[50]), formerly thought to be due to direct extension from the lung, but now considered analogous to the meningitis sometimes accompanying pneumonia and a septic inflammation. (*d*) Pyæmia (1396[45]) a rarer cause. (*e*) Ulcerative endocarditis, due to direct extension through heart wall, or both resulting independently from a poison circulating in the blood. (*f*) Tubercle (1445[50]), either part of a general tuberculosis or invasion of pericardium by a tubercular gland in mediastinum.

Passive effusion into pericardium.

1. Bright's disease.
2. Chronic valvular disease.
3. Leucocythæmia effusion, probably not due to mere anæmia.
4. Malignant growth of mediastinum from pressure on veins.

Effusion of blood.

1. Rupture of an aneurysm of first part of aorta.
2. Aneurysm of heart itself.
3. Puncture of coronary artery in paracentesis.

Effusion of blood-stained serum, due to malignant growths or injury in paracentesis.

Purpuric spots (1428[20]) best marked in purpura, but very common in all forms of severe fevers and diseases of lungs causing circulatory obstruction.

Milk patches on front of right ventricle, probably due to friction.

Fibromata (151).

Malignant growth.

1. Invasion from mediastinum.
2. Secondary deposits (1449[33], 1449[26]).

Dermoid cyst (3448).

From the Gazette's Special Pathologist.

ALL specimens, especially tissues and growths, should be accompanied by a short history.

M. D., CANONBURY.—Will refer to former specimen.

F., ROMFORD.—The tumour sent is a spheroidal-celled carcinoma.

W. H. R., KINGSTON.—Tubercle bacilli are present.

E. W. W., HITCHIN.—Tubercle bacilli are present.

T. H., GARSTANG.—The thyroid sent is involved by an epitheliomatous growth. No mention was made in your communication as to the prevalence or absence of a primary growth in pharynx. I should be pleased to receive information on this point.

C. T., TOOTING. — Large bacilli were present in quantities in the alveoli of the soft broncho-pneumonic patches of lung. Cultivation was impossible, so that the putrefactive origin is not altogether excluded. The bacilli were apparently all of one species. There is much bronchitic and peribronchial change in the lung.

G. S. H., BALHAM.—Tubercle bacilli were present in both the specimens sent.

PATHOLOGIST.

Specimens for examination and description in this column should be addressed to H. HUNT, GAZETTE, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Nervous System.

Philip	3.	Right hemiplegia. Syphilis.
	8.	Sciatica.
	13.	Wasting and loss of power in arms. ? Cause.
	18.	Cerebral tumour. Optic neuritis.
	16.	? Cerebral tumour. Clearing up optic neuritis.
	25.	Cerebral tumour. Optic atrophy.
Stephen	11.	Right hemiplegia and aphasia. Cerebral hæmorrhage.
	12.	Cerebral tumour. Optic neuritis.
	19.	? Locomotor ataxy.
Mary	8.	? Peripheral neuritis.
	35 & 15.	Exophthalmic goître.
	19.	Cerebral tumour. Optic atrophy.
	21.	Hysterical paraplegia.
	42.	Diffuse myelitis.
	43.	Locomotor ataxy.

Respiratory.

Philip	12.	Thickened and adherent pleura. Bronchiectasis. Lardaceous liver, spleen and kidney.
Stephen	8.	Empyema following pneumonia.
	13.	Left lobar pneumonia.
	18.	Chronic laryngitis.
	24.	Empyema.
	38.	Phthisis.
Mary	2.	Phthisis.
	4.	Healed phthisis. Thickened pleura.
	10 & 24.	Phthisis.
	47.	Broncho-pneumonia.
	48, 45, 46, 25 and 26.	Phthisis.

Circulatory System.

Philip	1.	Mitral regurgitation.
	2.	Mitral. ? Ulcerative endocarditis.
	3.	Pernicious anæmia.
	27.	Mitral regurgitation.
Stephen	1.	Dilated heart. Albuminuria. Cystitis. Orchitis.
	2.	Ulcerative endocarditis.
	4.	Mitral. Ascites.
	14.	Aortic regurgitation.
	28.	Mitral.
Mary	5.	Mitral and aortic regurgitation.
	17.	Aortic and mitral regurgitation.
	33.	Mitral stenosis and regurgitation.

Abdominal.

Philip	4.	Enlarged liver. Jaundice.
	6.	Fæcal fistula.
	17.	Enlarged liver. ? Malignant.
	31.	Perityphlitis.
Stephen	6.	Tuberculous peritonitis.
	16.	? Gastric ulcer.
Mary	13.	Enlarged spleen. ? Leucocythæmia.
	14.	? Malignant disease of stomach. Enlarged liver
	38.	Gastro jejunostomy.
	44.	Malignant disease of liver.
	50.	Tuberculous peritonitis.

Renal.

Philip	9.	Gout. Granular kidney.
	30.	Renal calculus.
	31.	Chronic nephritis.
	33.	Chronic nephritis.
Stephen	5.	? Renal calculus. Enlarged thyroid.
	25 & 27.	Acute nephritis.
	40.	Chronic tubal nephritis.
Mary	1.	Renal calculus. Nephrolithotomy.
	10.	Chronic tubal nephritis.
	18.	Chronic tubal nephritis. Retinitis pigmentosa and albuminuric retinitis.
	37.	Acute nephritis. Erythematous rash.

Philip	36.	Tuberculous ulceration of skin.
Stephen	20.	Gout, pleurisy, and bronchitis, hypertrophied and dilated heart.
	21.	Typhoid.
	31.	Dysentery.
	39.	Varicella.
Mary	27.	Myxœdema.
	23, 29, 34 and 41.	Typhoid.

Cases Under Dr. Pye-Smith.

Mary.

27. M. B., æt. 36. Admitted 9th May, 1894, for swelling of face, legs and hands. Patient is married and has five healthy children.

History of present illness.—Seven years ago patient had a bad confinement, and before she recovered swelled all over. This lasted three or four weeks, then went down but did not quite disappear. Since then it has recurred for two or three weeks, at intervals of a few months, never quite going away. At intervals of two or three months patient has had attacks of diarrhœa lasting three or four days. She is constipated in the intervals. No vomiting or twitching of the limbs. No headache until the day she came in. She says she does not drink more than a pint of beer a day. She passed more water than usual during the first part of her illness, and occasionally since.

Condition on admission.—Patient is stout. There is puffiness of the face and œdema under the eyes. Complexion is sallow, with red patches over the malar bones. Hands do not pit on pressure, but they are thick, rough, and the ring cannot be got off its finger. Feet and legs slightly œdematous. Patient's hair is falling out; the teeth are getting loose. *Urine.*—Sp. gr. 1002; neutral; a trace of albumin; a thick deposit of squamous cells. *Circulatory and respiratory* systems normal. Since admission there has been no albumin in the urine. Temperature normal.

Diagnosis.—? Myxœdema.

Dr. Pye-Smith considered the roughness of the skin of the hands, and the swelling under the eyes not pitting on pressure, and the fact that the thyroid could not be felt, important, and the falling out of the hair less so in making the diagnosis.

35. K. M., æt. 24. Admitted for pain in epigastric region and occasional palpitation of heart.

Family history. — No history of diabetes in her family. Patient was born in America, and came to live in Hereford when six years old, where she lived for fourteen years; for the last four years she has lived in London.

Previous illness.—Patient has never been strong; menstruation has always been irregular; since February two years ago, she has not menstruated; had rheumatic fever last year; in bed eleven weeks.

History of present illness.—Four years ago patient went to Brompton hospital for "cough and bringing up blood," she remained there nine weeks and was discharged as better. For eighteen months patient has complained of "pains in her stomach"; worse immediately after food. About four years ago patient first noticed that she was becoming nervous, that her heart used to beat very fast at the least excitement, and that her eyeballs were becoming prominent.

Present condition.—Temperature 99; pulse 120; respiration 40. Patient is well nourished; no palpable enlargement of thyroid, but a faint systolic bruit can be heard over it; eyeballs prominent; upper lid does not move synchronously with the eyeball; some blinking of the eyes; patient can shut her eyes quite tight. There are a large number of small brown pigment spots on the hands and lower part of forearms (she does not expose her arms to the sun). Very fine tremor of hands. Patient complains of pain all over right side of abdomen. Pulse is rapid; heart beats forcibly; patient is very nervous and excitable. *Diagnosis.*—"Exophthalmic Goître."

28. E. B., æt. 37. Admitted May 15th, for jaundice and weakness. Parents died of phthisis. Husband died nine years ago of phthisis. Four children, one living. First child had snuffles. Last severe illness was small-pox when fourteen years old. Has had sore throats, but no indications of syphilis. Has had pains in the epigastrium for years. After a hearty meal of boiled carrots, she had pain in back and chest. Next day confined to bed, vomited six times. The third day she returned to work, and the fourth day she became jaundiced and felt very weak, and was admitted to the hospital. She is perspiring freely; temperature 99; pulse 70; respiration 24. Lungs normal. Systolic apical bruit. Right kidney prominent. On deep palpation a hard lump was felt at the level of the umbilicus, and between the sternal and nipple lines; above it the edge of the liver can be felt, and the gall bladder (?) Urine 1028; albumin (she is menstruating), no sugar; bile pigments, no blood; a quantity of pus (leucorrheal), colour bright red.

Diagnosis.—Icterus simplex.

Treatment.—Liq. Bisth. et Ammon. Cit. ʒi. Decocti Taraxaci ad ʒii. t.d.s.

Progress.—May 17th. Skin much clearer; temperature 99; pulse 90.

19th. Face quite normal; body and conjunctiva just tinged.

37. H. D., æt. 54. Admitted May 12th, for headache, vomiting, and swelling of legs and abdomen. Occupation, cleaning offices. Mother and two children died of phthisis. Father suffered from rheumatism. Has had eleven children; seven of them are living. She had one miscarriage. Had small-pox when a child, and has never been vaccinated. She had not had any rheumatism. During last few months has suffered from cold and night sweats, has lost flesh, and brought up "black" sputum She has always suffered from headaches; these have become more severe lately. On May 4th she became faint and had a rigor, with pain across the chest. Went to bed, but could not lie down, because of impeded breathing. During the next few days she vomited frequently. On May 11th her legs began to swell, and she came in next day. Temperature 99; pulse 82; respiration 24. Lungs normal. Heart-sounds normal. Pulse regular; rather high tension. Urine 1012, very dark, contains blood, pus, blood-granular and hyaline casts; crystals of triple phosphates; albumin ·2 per cent.; urea 1·3 per cent. Passed ʒ iv. on the first day.

Diagnosis.—Acute nephritis.

Treatment.—

Liq. Ammon. Acet. ... ʒii.
Syrupi Chloral ... ... ʒi.
Infus. Jaborandi ... ... ʒi. t.d.s.
Injec. Pilocarp. Nit. ⅓ gr.

May 18th. A faint systolic apical bruit.

21st. An erythematous rash has come out all over the body.

CASES UNDER DR. TAYLOR.

STEPHEN.

19. R. V., æt. 53. Admitted for pains in legs and loins and staggering walk. Patient had small-pox when he was fifteen; "abscess" in left groin at the age of eighteen; no history of syphilis or gonorrhœa obtainable. Patient has had to have a catheter passed three times since last November, owing to difficulty in micturition. Patient considered himself strong and healthy until ten years ago, when he had pains in the legs, with weakness and

twitchings, and a feeling of weakness in his loins. Patient says his calves became slightly swollen, but were never tender; the pains were shooting in character, and extended all the way down his lower extremities. Patient says the pain gradually became worse, and at the same time he became very weak, being unable to stand. Patient went to Canterbury Hospital, where he remained eleven weeks, and attended as an out-patient for five more weeks; three weeks of that time patient's legs were galvanized night and morning. At the end of that time patient felt quite well, and had no further trouble for nearly seven years, when he had operations performed on both ears for continuous pain and deafness. Since these operations, patient has always had an offensive discharge. Patient ruptured himself three years ago; patient's sight has been failing the last two years.

History of present attack.—Fifteen months ago, patient had an attack which was very similar to the one he had ten years ago, but not so severe; patient has been able to walk all the time, but feels unsteady, and has great difficulty in walking at night; patient had shooting pains down his legs, and a feeling of weakness in his loins. Patient went to the hospital at Canterbury soon after the pains commenced, and about two weeks later he suffered from a severe "drawing" pain in his rectum, which has lasted ever since, being worse at times. Patient looks "alcoholic," but denies being so; patient says he has not wasted; patient has great loss of power in both legs and slight inco-ordination; gait slightly ataxic; patient cannot stand with eyes shut; no paralysis of ocular muscles; hyperæsthesia in both legs with delayed sensation; localization good. Patient has "arcus senilis" and considerable choroidal degeneration. Knee-jerks and plantar reflexes absent, pupils react to light and accommodation; electrical reactions normal. Patient has partial retention of urine, and has to have catheter passed occasionally; colour-vision, good; taste and smell normal. Patient jumps up in bed when certain points are touched on his spine, but the points vary considerably in position and he seems very neurotic.

Diagnosis.—? Locomotor ataxia.

20. Patient is a farrier by occupation, and up till last Christmas was always hale and hearty. At that time, being out of employment and consequently underfed and exposed to wet and cold, he experienced "pains in his sides," and used to spit up yellow phlegm. This condition passed off and he was fairly well until five weeks ago, about April 8th, when he began to suffer from shortness of breath. His feet began to swell about ten days ago.

On admission.—His temperature was 95·6. He lies flat in bed, breathing comfortably, but suffering from a hacking cough, which catches him now and again.

On examination, his chest is barrel-shaped; there is a pleuritic rub in right axilla, while behind, below the angle of scapula on right side, is dulness, with absence of breath sounds and râles, which are also present on left side below angle. There is no cardiac dulness; no visible impulse, a systolic bruit is heard at apex, and it can be traced a short distance into the axilla. The left big-toe-joint is swollen and tender, so also are both ankles. A tophus on left ear.

Diagnosis.—Gout, bronchitis, emphysema and pleurisy.

Mary.

43. Patient is a married woman, æt. 42 years. Family history does not show consumption or heart trouble. There is a history of syphilis. Had jaundice sixteen years ago, but no other severe illness until the present, which began nine months ago with ulcers on the feet. Then, seven months later, followed sharp shooting pains in the legs, with numbness from the thigh downwards, and a certain amount of difficulty in walking. Lately her appetite has been bad. Her periods have always been too frequent, and latterly irregular.

Condition on admission.—Argyll-Robertson pupils; knee-jerks; wrist and elbow-jerks absent. No paralysis or paresis. Inco-ordination of lower extremities. Shooting pain in back part of left thigh. Tactile sensibility decreased in lower parts of both legs. Two perforating ulcers on the sole of the left foot, and one on the right.

Heat and cold sensations somewhat mixed up. Two enlarged bursæ over left knee. There are no crises of of any kind, and no respiratory or circulatory complications.

Diagnosis.—Locomotor ataxia.

Treatment.—Galvanism.

℞ Liq. Arsenicalis ... ♏ iij.
Inf. Calumbæ ... ʒj t.d.s.
Ung. Iodoformi for ulcers.

The chief points of interest in this case are the perforating ulcers, their small size and great depth, the fact that they were noticed seven months before any other symptoms, and the occurrence of the disease in a female.

Cases under Dr. Goodhart.

Mary.

15. Admitted for exophthalmic goitre. One sister died of Graves' disease last July. No history of diabetes or mental disease. Present illness began four months ago with swelling in legs. Patient felt weak and tired, had good deal of dyspnœa on exertion, and also palpitation of heart. Exophthalmos and swelling of the thyroid gland have come on lately. Patient shows the three cardinal symptoms of Graves' disease rather well. The eyes are large, prominent, and staring. The thyroid body is a good deal enlarged, and a harsh systolic bruit heard all over it with the stethoscope. Thrill also felt; heart sounds rapid; soft systolic bruit at apex, and harsher bruit over pulmonary area. Good deal of pulsation over third and fourth left spaces. Apex beat very diffuse. Pulse 140. Venous hum in veins of neck. Tremor of limbs and twitching movements of hands and fingers. Skin hot and perspiring. Temperature 101.

Dr. Goodhart advises removal of the isthmus of the thyroid gland. He thinks the gland will then shrink.

Case under Dr. Hale White.

Mary.

5. F. M., æt. 8. Admitted for heart disease. No family history of rheumatism or cardiac affection.

Previous history.—Chorea four years ago, absent for last six months; acute rheumatism two years ago, and a second attack six months ago; has since suffered greatly from shortness of breath.

Present illness began on 3rd inst. with aggravation of the dyspnœa, with vomiting and præcordial pain. Patient vomited several times; no joint pains; no rigors.

On admission.—May 7th. Pulse 140, regular and full respiration 54; temperature 100. Patient pale and distressed. *Heart.*—Systolic murmur at apex in sixth space outside nipple line. Dulness was rectangular in shape, and extended up to third rib. Pericardial rub heard at base. *Lungs.*—No signs of fluid; no swelling of abdomen or legs; no joint pains; no nodules. Temperature rose at 10 p.m. to 104·8; no rigor.

8th.—Temperature 101·2. Cardiac dulness unaltered. Loud râles and rhonchi audible over front and back of chest. Patient suffers from sudden attacks of dyspnœa and violent coughing. Dr. Hale White prescribed Tinct. Digit. ɱiij., Caff. Citt. gr. v., Ag. Chloroform ad ʒss, 4tis horis. Brandy ʒij. 4tis horis. 9th.—Patient vomited during the night, and owing to its persistence, Dr. Hale White prescribed Tinct. Convallaria Majalis ɱiij., Tinct. Nucis Vomicis ɱiij., Acid Hydrocy. Dil. ɱiij., Aqua Carui ad ʒss, 4tis horis. Brandy to be discontinued. 10th.—Patient better, no further sickness. Pericardial rub disappeared. Temperature keeping down. 12th.—The following bruits were heard to-day: at the apex a systolic and an early diastolic; to the left of sternum in second and third spaces, not audible on right side of sternum—an early diastolic. Farinaceous Diet. 18th.—Patient continues to improve. Apex unaltered in position. Well marked epigastric pulsation. A distinct undulation is visible over the pericardial area during the systole. Râles and rhonchi are much less numerous. 21st.—Full diet. The bruits now present are as follows:—At the apex, a short presystolic and loud systolic to the left of sternum; in second and third spaces is a diastolic bruit. Dulness continues up to the third rib, and the position of apex remains unaltered. Pulse is 110; respiration, 38; temperature, normal.

Dr. Hale White's diagnosis was:—Pericarditis; adherent pericardium; mitral regurgitation and stenosis; ? aortic regurgitation.

The diastolic bruit heard in second and third spaces might be due to (i.) aortic regurgitation; (ii.) pulmonary regurgitation.

In favour of the latter is, its position.

Against it, - - its great rarity.
the splashing character of pulse.

Dr. Hale White also brought out the following points:—That much pericardial effusion was probably not present at any time during this case, as the area of dulness did not extend high enough, and was much the shape of the normal cardiac dulness.

That in similar cardiac cases, where Digitalis is found to produce sickness, the following must be tried in turn:—Convallaria Majalis, Strophanthus, Erythrophlœcum, Barium Chloride. The value of this method was well exemplified in this case, where Digitalis produced repeated vomiting, but where convallaria majalis has proved beneficial.

The prognosis was at first thought to be fairly good as regards the immediate future; when puberty was reached, and an increasing demand made on the system, patient would probably go down hill. The pericardium is now thought to be extensively adherent owing to the unaltered abnormal position of the impulse, in spite of the rest in bed and treatment; this condition makes the prognosis graver in character, as there is little probability of the ventricle contracting up from its present dilated condition.

8. M. B., æt. 45, a single woman. Admitted for paraplegia on May 16th. Patient does not seem to have ever enjoyed good health. She has had pleurisy; suffered with dyspepsia for years; influenza twice, the first time twelve months ago, the second last Christmas. Patient has suffered with "weakness in the legs" since the first influenza attack. Patient was quite well for three weeks after second attack, when she noticed that her legs became weak. She was at first able to get about, but has been unable to leave her bed for about nine weeks; there was no pain in the legs. Patient had bad headaches with occasional vomiting; she sometimes "reeled about" when washing her face, but there is no history of ataxy.

On admission.—Patient was quite unable to walk; no evidence of ataxy; legs were slightly rigid, there was *no foot drop*, but great *loss of power*; no spasm nor incoordination; slight anæsthesia, analgesia, and loss of sensibility to hot and cold sensations irregularly scattered over both legs up to knees.

Reflexes.—Plantar present in right foot, absent in left; both *knee-jerks absent;* abdominal or epigastric reflexes present. No clonus.

No *pain or tenderness* on pressure over nerves. Electrical reaction good; no *reaction of degeneration.* No urinary nor rectal trouble.

Pupils contracted; loss of light reflex doubtful. Patient is slightly deaf.

Heart and Lungs normal.

Dr. Hale White first pointed that the paralysis was not merely weakness, because there had been a three weeks interval between the influenza attack and its onset, and as there were absent knee-jerks.

As the pupils were contracted, and there was a doubtful loss of light reflex, the possibility of *Locomotor Ataxy* was raised. *In favour* of this view were:—

(a) The contracted pupils and doubtful loss of light reflex.

(b) The occasional vomiting, doubtful gastric crises.

(c) The absent knee-jerks.

(d) The sensory symptoms.

Against were:—

(a) The absence of ataxia and lightning pains, and the great doubt as to whether the vomiting was due to gastric crises.

(b) The great weakness and loss of power.

(c) The rarity of the disease in women.

(d) The rarity of the disease as a complication of influenza.

(e) The sudden onset of the disease after influenza.

Dr. Hale White thought locomotor ataxy could not be diagnosed, chiefly for the first two reasons against it, and laid great stress on the second one, as in locomotor ataxy; the opposite sign is a striking feature in the disease.

Peripheral neuritis following influenza was diagnosed for the following reasons:—

(1) It is a fairly common complication of influenza.

(2) The sensory symptoms in association with

(3) The great weakness and loss of power in the legs.

The present electrical condition of the muscles was explained by the time that has elapsed since the onset of the neuritis. The loss of knee-jerks was regarded as due to the peripheral neuritis. It was pointed out that the loss of power sometimes seen with locomotor ataxy was nearly always slight and usually transient.

In the Surgical Wards.

Cases under Mr. Howse.

Charity.

18. E. H., æt. 44. Admitted May 16th, for a hard, non-fluctuating swelling of right breast, involving the whole gland. Patient gives a history of blood-poisoning of her right arm, in November 1893, due to a prick from a rose-tree thorn. Her arm was very much swollen and painful; she was ill until about February, 1894. During this illness she noticed an oval swelling, about the size of a pigeon's egg, situated behind the anterior fold of axilla. This swelling neither increased nor diminished, and in a short time another swelling became evident in the axilla itself. Following this, the mamma began to be invaded, patient's notice being first attracted by pains which first began in the glands in the axilla, shooting into the nipple; swelling rapidly following. The nipple is of normal size and shape; is not retracted; it is not inflamed, nor is there any discharge. Breast is enlarged, firm in consistence, no fluctuation; skin over it is tense, hot, thickened, and œdematous, and more or less fixed to subjacent structure; axillary gland enlarged. Diagnosis is carcinoma.

9. H. B., æt. 36.

Patient's family history.—Father strong and healthy; one brother strong and healthy; mother died of consumption, age not ascertainable.

History of present disease.—Nine weeks ago patient noticed a small swelling just above right nipple, which has gradually extended upwards and to the left; patient cannot account for its appearance.

Condition on admission.—Patient has a large swelling on the upper part of the front of the thorax, its lower border commencing on right side just above the nipple, extends obliquely upwards to left border of sternum, on a level with third intercostal space. Right margin of swelling extends upwards, in a vertical line, from right nipple to within two inches of lower border of clavicle; upper border runs transversely. On pressure the most painful parts correspond with second and third right costal cartilages, at their junction with the sternum. Skin over swelling not inflamed. Considerable fluctuation can be obtained. On palpation there is no dulness over chest.

Operation.—Mr. Howse opened the swelling whilst the patient was under $CHCl_3$, dividing the structures down to the pectoralis minor, and then, plunging in a director, opened up the sac, drawing thereby ʒv. of dark yellowish green pus, and two large masses—the size of bantams eggs—of caseous pus were extracted; a small abscess cavity was found in the sternum, which was then well scraped.

Dr. Pitt examined patient and found chest notes below average, breath and voice sounds in front normal; breathing over right supra spinous fossa indeterminate, coarse at fifth vertebræ; no moist sounds.

Naaman.

1. J. B., gamekeeper, æt. 46. Has had rheumatic fever, and rheumatism in right shoulder and arm; mother suffers from rheumatism. Three years ago patient had aching pains in left shoulder—suddenly got worse, two years later being so bad as to prevent patient using his arm. Patient was put under $CHCl_3$ at Swansea, and the adhesions broken down; shortly after patient's arm became much swollen, and went quite black over bicipital and outer pectoral regions; adhesions subsequently broken down again twice, under gas, and patient took Turkish baths, and underwent massage, but with no good result.

On admission.—The arm is wasted; shoulder movements very limited; on rotating head of humerus, "crackling" is felt; slight shortening of arm. Patient was put under $CHCl_3$ and the head of the humerus excised. Large masses of detached degenerated cartilage were found loose amongst the muscles. The bone removed was one and a half inches long; the shape of the head was quite destroyed; all the cartilage had disappeared. On external aspect of posterior surface of bone removed is an opening leading into a large cavity in the interior of the bone, which is almost filled with a sequestrum. Patient's highest temperature has been 100·4, and that only for one evening. Is doing very well.

Cases Under Mr. Davies-Colley.

Luke.

6. R. S., æt. 43. Melanotic growth from mole. Patient came in for lumps on the arm. Twelve months ago a small mole on the front of middle of left arm began to enlarge; four months later a lump appeared a little above the mole, about an inch below the elbow;

four days ago a small lump appeared in axilla, and has rapidly increased in size since.

On examination, the mole is found to be about the size of a shilling, covered with rough, raised, dark-red scab, with some signs of ulceration. The lump just above it is a globular swelling about the size of a bantam's egg; uniformly tense; skin over it reddened; not painful. In the axilla there are several glands enlarged, one mass forming an oval swelling at inner wall of axilla about two inches long; they are very painful. Patient's temperature is 101·3.

15. C. P., æt. 38. Admitted for frequent and painful micturition, with thick urine. Six months ago patient noticed a tender spot about three inches above lymphysis pubis, caused, he thinks, by a recent attack of vomiting. Four months ago he had at the end of micturition pain, with the passage of thick urine, containing white flakes; also had frequent desire for micturition. A fortnight ago patient passed a piece of white tissue, like "fat meat, only lighter, and of lesser texture," about the size of a Barcelona nut; this had caused a temporary stoppage, otherwise his stream of urine has been good. Sometimes passed a little blood. His urine contains albumin, pus, and is acid. A swelling can be felt at the before-mentioned tender spot. A rectal examination shows another swelling about the position of prostate.

Case under Mr. Golding-Bird.

Lazarus.

Case of popliteal aneurysm, operated upon two years ago, and remaining well till present time, when slight pulsation has again returned in the tumour. The femoral has been tied in Scarpa's triangle. There is a hard tumour in the course of the popliteal artery, which presents very feeble pulsation, not sufficient to characterise as expansile. This diminishes on pressure of femoral artery in thigh. There is weakness in leg, and shooting pains down outer side.

Case Under Mr. Symonds.

Martha.

Girl with fixation of lower jaw, due to cancrum oris of cheek, following typhoid fever last year. Mr. Symonds removed a wedge-shaped piece of bone from lower jaw on left side, and formed a joint by driving a thick piece of wire into each cut surface of the jaw, and bending the free ends of the wire into two loops, one loop embracing the other, allowing thus free movements of the fore part of the jaw on the hinder.

Case under Mr. Lane.

Job.

19. Boy. Admitted April 8th, with history of discharge from left ear for past twelvemonth. Was hit over ear fourteen days before admission. Since then has had increasing one-sided pain with intense headache, vomiting, pyrexia and rigor on day of admission. Was operated on same evening. In doing so the anterior wall of a subdural abscess was torn and a thrombus with profuse hæmorrhage ensued. Mr. Lane at once tied the internal jugular, cleared out the abscess, which at first was thought to be lateral sinus, then slit up the sinus, which was thrombosed by this time, stuffed the wound and put the patient back to bed. The abscess cavity apparently communicated with the sinus by its posterior wall. Patient's temperature fell from 103 to 93 that evening, but two days after had a rigor. Mr. Lane then exposed the sinus again and opened it up, removing a large septic thrombus, the whole wound was plugged with solid iodoform. Little good seemed, however, to result from these operations as patient continued to have rigors and pyæmic fever, his temperature at one time reaching 107. Between the high temperatures patient seemed quite well, and took eggs, milk, beef-tea in quantities, besides enormous doses of Hg. As., Pot. Iod. and Strychnine. On the 24th patient had severe pain on right side in mid-axillary line, no rub heard, was relieved by a Belladonna plaster, and is bringing up quantity of white frothy sputa.

30th. Dulness at right base; needled, no fluid found.

May 3rd. Aspirated and five ounces of serum drawn off, containing a few pus cells. Patient much easier after this; lying for the first time on his left side since he came in.

6th. Right lung dull almost to the top, neither breath nor voice sounds to be heard. Bringing up quantity of very foul sputa. Thought to have abscess in lung with fluid overlying it. Later on signs of consolidation appeared on left side. Patient gradually got weaker and died on the 19th, just six weeks since his admission. At the post-mortem 42 ounces of pus were found in right pleural cavity; the whole of the right lung was in an advanced state of grey hepatization, and there were consolidated areas on left side; also signs of old meningitis. The pneumonia no doubt began as small pyæmic patches which gradually coalesced into one large area. As regards the fluid in the chest, it is probable that there was a good deal more present on May 3rd than was drawn off. Other points of interest are the long duration of the case, also the fact that the lungs were the only organs secondarily infected. The fluid was no doubt secondary to the pneumonia, and the operation was entirely successful as regards the head condition.

Calendar of Coming Events for May.

May 28th.—1st XI. v. Surrey Club and Ground, at the Oval.

„ 30th.—Guy's Hospital Rifle Association v. Dulwich, at Bromley.

1st XI. v. Ealing, at Honor Oak Park.

„ 31st.—Guy's Hospital Christian Union. 4.30, Address by Rev. T. H. Darlow, "Religio Medici."

Passim.

We have been asked to draw attention to the vacant appointments in the Medical School, announced in another column. With regard to the majority of the vacancies, it is thought that the present holders will apply for re-appointment. One of the Demonstratorships of Physiology and Biology is, however, a new appointment; we understand that Mr. Dunn does not propose to apply for reappointment in the Dissecting Room.

The establishment of a new Demonstratorship of Physiology and Biology is, we are informed, the outcome of certain re-arrangements in the teaching of Elementary Biology rendered necessary by the revised Schedule recently issued by the Conjoint Board, and published some weeks ago in the Gazette. The three months' practical course of Biology hitherto given will be next year expanded into a six months' course, commencing in October, and a shorter practical course for *referred* candidates and for first year's men entering in January will be held during the Summer Session.

We have, of late, ceased to reproduce examination questions in our columns, thinking that, as they are mostly to be seen elsewhere, the space they occupy is disproportionate to their value. But accounts of vivas, especially those at the First Fellowship, are on a different footing, and may often give a valuable indication of the standard required. We publish one such to-day, and shall be glad of others.

We heartily congratulate the successful candidates at the recent First Fellowship examination, and also congratulate the Medical School on the high percentage of successes. Nine out of thirteen is a proportion to be proud of.

At the L.D.S. examination we also came off well, with a pass list of nine out of thirteen. At the L.D.S. Ireland we were especially glad to notice among the successes the name of Mr. Stoker, whose recent stay at Guy's was so great a gain to our football. Our athletes have been scoring off the examiners lately.

We hear that an arrangement has been arrived at, whereby the Inter-Hospital cricket matches will be played on our ground at Honor Oak Park. Matches in which Guy's take part will, of course, be excepted from this arrangement.

The Biennial Dinner is to take place on July 18th. As we urged the other day, a large attendance may be expected this year; *inter alia*, because many old Guy's men have expressed a hope that they may meet Mr. Durham there. We hope, therefore, that plenty of accommodation may be provided.

The Distribution of Prizes will take place at the Hospital on the same day.

Mr. Targett (as Erasmus Wilson Lecturer), is to give a course of three lectures at the College of Surgeons, on "The Pathology of Hydatids in Bone, and of Tumours connected with the Kidney in Children." The first lecture, dealing with hydatids in long bones, takes place on Monday next, at five o'clock. The remaining lectures are to be given on Wednesday and Friday, at the same hour. We hope to publish a special report of this course in the Gazette.

Our paragraph referring to the neglect of Weismann's Romanes-lecture has raised the ire of one or two Oxford correspondents. We can only say that the London papers gave full publicity to the fact—one of them under the heading, "The Unpopularity of Science." For

the expression "Small profits and quick returns," as defining the present nature of the intellectual activity at the University, we were not responsible; it was quoted from the *Contemporary* article.

BUT, at the same time, we certainly gave ourselves away pretty badly by spelling the Professor's name wrongly. We were fortunate in our mistake, however, for it extracted the following from that clever rhymester, the author of "Conjoint Board Carols":—

DEAR SIR,
You're a nice man
To say that Herr Weissmann
At Oxford has lately been slighted!
It's really a shame, sir!
No one of that name, sir,
Is known in the city you've cited.

If you were a wise man,
You'd know that Herr Weismann
Is the only correct way to spell him.
I should really have thought, sir,
His works you'd have bought, sir;
But you can't have! (Never mind, I won't tell him!)

Still, perhaps Herbert Spencer
Is *your* prophet, and hence, sir,
You refuse to admit he's a *weis' mann*.—
But I fear I'm a bore, sir,
So I'll say nothing more, sir,
And remain, yours, etc.,
A GUY'S MAN.

To which we reply—

Be it Weismann or Weissmann
We see in a trice, man,
Your "environment" once held the Isis;
You else would confess, sir,
An "s" more or less, sir,
In *Passim* is scarcely a crisis!

Your quibble is meant, sir,
For crossing the scent, sir,
'Tis just a red herring you're trailing;
You grieve at the chasm
'Twixt Oxford and "plasm,"
So, forsooth, at our spelling you're railing.

True: our prophet *is* Spencer,
We do not dissent, sir,
Yet *we* can do honour to Weismann;
But *small prophets*—like Green, sir
(T. H. G. we mean, sir),
Have spoilt you for hearing a wise man.

BUT we must certainly look to our spelling of proper names, or we shall be no better than professional journalists in this respect. The other day we wrote Professor Humphry's name as "Humphrey," whereupon we were castigated by an old contributor, who always was a purist. He used to rave in our columns about such misuse of forms as "condyloid" for "condylar," and he wanted to re-christen the *Descendens Noni* (as will be remembered by diligent readers of the GAZETTE) almost before its new pedigree had been made out. But why does he not work for us now; he was of our very best. To conclude the list of our recent liberties in the matter of names we have to confess that the "Mr. Craal" who was said to have read a paper before the Dental Society was, of course, Mr. Oram.

OWING to certain remarks in the GAZETTE, aided by the individual efforts of a praiseworthy gentleman, who, by the way, hails from "practical" Oxford—but, above all, owing to the sweet reasonableness of the authorities—a new set of dressers' lockers is to be provided. The old bookcase which occupies the wall opposite the the swing-doors of the library is to be removed, and the lockers will take its place.

IN a letter to Dr. Muncaster, acknowledging the receipt of the wedding gift from the students at Guy's, Dr. Pye-Smith wrote:—"Of all the many expressions of friendship from colleagues and old and new kinsfolk and valued friends that I have received on my marriage, there is none which I prize more than this gift—costly and beautiful in itself, and endeared to me by the warmest feelings of my heart for our beloved Hospital, and for all those who have been my pupils and fellow-workers in its wards. Nothing will give in future, as it has given in the past, so much pleasure as to hear of the health and happiness and success in life of those whom I am so closely bound to."

An Observation on the Incubation Period of Scarlatina.

A boy, aged 15, came to the Surgery early on Wednesday, May 16th, complaining of sickness and prostration. Twenty-four hours before he was seized with headache and sore-throat. On Wednesday morning, temperature 100; pulse 124. The tongue was uniformly coated. Both tonsils somewhat enlarged, deep-red and succulent looking; there was a circular, superficial, sloughy ulcer on the right one. The neck was swollen, and the submaxillary and superficial cervical glands were large and tender. On the upper part of the chest a faint, finely-punctate, diffuse, rose-red blush could be seen. Diagnosis scarlatina. The point of interest of the case was in the incubation period. On Friday afternoon, the 11th, he was playing with another boy, apparently in perfect health. Next morning the other boy developed a rash and other symptoms of illness, which was certified to be scarlatina, and he was removed. The patient did not see the other boy after Friday afternoon. Three and a half days from the time of seeing the other boy, and just three days after the other boy developed the rash, the patient sickened, and exactly twenty-four hours afterwards developed his rash. The incubation in the second case may therefore be taken as three and a half or four days. Authorities give the incubation period as follows:—"Varies between six and eight days, but is occasionally longer, and very often less" (Bristowe). "Rarely more than seven or eight days—sometimes probably only twenty-four or thirty-six hours" (Taylor). "Two to five or six days; occasionally much shorter" (Fagge). At the London Fever Hospital, I believe the average period is taken to be three days. Dr. Collie says it varies from some hours to some days, and may be as short as three days, but rarely extends beyond a week. He quotes a case in which the incubation period was not more than eleven hours.

A. J. S.

Guy's Hospital Dental Department.

Practice during April, 1894.

Gold Fillings		213
Amalgam		
Osteo		447
Perm. G.P.		
Temp. G.P.		
Artificial Crowns		24
Dentures		21
Dead Teeth		99
Scalings		38
Regulation Cases		3
Attendances for Extractions under Anæsthetics		612
,, ,, without ,,		447
Total		1904

Royal College of Surgeons of England.

An ordinary meeting of the Council of the Royal College of Surgeons of England was held on the 10th inst., the President, Mr. J. W. Hulke, F.R.S., in the chair.

Mr. Chauncy Puzey was introduced and admitted a Fellow of the College.

Mr. J. McCarthy was re-elected and re-admitted as a member of the Court of Examiners.

Syllabus of Three Lectures on The Pathology of Hydatids in Bone, and of Tumours Connected with the Kidney in Children, To be delivered in the Theatre of the College, on Monday, Wednesday, and Friday, May 28th, 30th, and June 1st, at 5 o'clock each day,

By James Henry Targett, M.S., F.R.C.S.
(Erasmus Wilson Lecturer.)

Lecture I.—Monday, May 28th. Introductory.—Hydatids in Long Bones.—Effects produced upon the diaphysis.—Absorption, expansion, spontaneous fracture.—Absence of periosteal reaction.—Influence of septic infection.

Hydatids in the articular extremities.—Necrosis.—Characters of sequestra.—Invasion of joints.—Clinical signs.

Lecture II.—Wednesday, May 30th. Hydatids in Bones of Pelvis.—Peculiarities.—Invasion of hip-joint and soft parts.—Hydatids in Spinal Column.—Curvature, compression of cord, infiltration of adjacent muscles.—Erosion by Hydatids.—Multilocular Hydatid Tumours.—Unilocular and Multiple Cysts.

Lecture III.—Friday, June 1st. Chief varieties of Tumours connected with the Kidney.—Relations to Capsule.—Retroperitoneal, subcapsular, cortical, and hilum growths.—Their anatomical characters.—Adrenal Tumours.—Aberrant Adrenals.—Summary.

Each Lecture will be illustrated by means of lantern-plates.

EDWARD TRIMMER, Secretary.

Guy's Hospital Medical School.

VACANT APPOINTMENTS.

Applications are invited for the following posts which will become vacant on the 1st of next October:—

1 Medical Registrarship.
2 Demonstratorships of Anatomy.
1 Demonstratorship of Anatomy with Biology.
1 Demonstratorship of Physiology.
2 Demonstratorships of Physiology with Biology.
1 Demonstratorship of Biology.
1 Demonstratorship of Chemistry and Physics.

Applications should be sent in to the Treasurer, at the Counting House, on or before Thursday, May 31st, 1894.

May 17th, 1894. L. E. SHAW, Dean.

Viva Voce for the Primary Fellowship.

ANATOMY.

[The sternum was given the candidate, who was asked to name it and indicate the position of the attached muscles; the relative positions of the origins and courses of sternohyoid and thyroid muscles were laid stress upon. The mode and centres of ossification were required, as well as the manner in which the proceeding cartilage was laid down, *i.e.*, in lateral halves.]

"What is this bone?"

"The external cuneiform."

"How would you distinguish it from the other cuneiforms?"

On the candidate pointing out the larger facet on the outer surface :—

"What bone is that facet for?"

"And the one in front of it?"

"Is it larger than normal?" "Yes."

"What is the usual manner of junction of the external cuneiform and fourth metatarsal?"

(Interosseous ligament required.)

"What muscles are attached to this bone?"

"Origin and nerve supply of the flexor brevis hallucis."

"Quite right, its chief origin is from the tendinous expansion, hence its variability."

"Is the fifth metacarpal bone distinguished?"

"Why is proximal facet of that shape?"

"What is attached to the tubercle on the base?"

"What is the action of the extensor carpi ulnaris?"

(Special stress was laid on adduction of the hand).

"Is this movement freer than abduction?"

"Why so?"

"How are these movements checked?"

"What are other such cases of bony impact, checking movements?"

"Why is there greater risk of dislocation outwards?" (relative size of articulating surfaces).

"Which do you call the head of the radius?"

"What is its ossification?"

"How much of the proximal extremity is epiphysical?"

"Is the epiphysis entirely intracapsular?"

"How far downwards does the olecranal epiphysis extend?"

"What other instances have we of epiphysial lines in joints?"

[Dissection in spinal of posterior mediastinum.]

"What is this?" (Thoracic aorta.)

"Give the course and relations of a right aortic intercostal artery."

"What is the ultimate distribution of its dorsal branch (especially spinal branch)? Relation of structures in an intercostal space?"

[The sympathetic cord was then taken up and inquired about.]

"What is this nerve? (The great splanchnic) Its origin and that of the other splanchnics?"

"What are the structures on which the various ganglia lie (heads of ribs above) — and below?" (The vertebræ).

"Why do the cords converge below?"

"To get to the solar plexus near the mid-line."

"Yes, and also because the bodies here are wider."

"How many thoracic ganglia lie on the vertebræ?"

"Yes; the lower two."

[Dissection of arm.]

"This is? (The flexor sublimis digitorum)—and its origin?" (*Bell.*)

PHYSIOLOGY.

"What is under that microscope?"

"A vessel. Well, a capillary."

"No: why a vein, and not an artery?"

"What are the elastic structures in an artery's coats, and in which coats?"

"Do the fibres take the form of membranes or remain as separate fibres?"

"Look under the next microscope."

"Oh, developing tooth."

"What parts do you see?"

"What are the three layers of the enamel caps?"

"What is their origin?"

"How is the enamel of the permanent teeth produced?"

"Does this out-growth form the temporary tooth—enamel caps appear before or after birth?"

"Name the parts in succession you see here" (section of auditory apparatus).

"Of what form is the articulation between the malleus and incus?"

"Is there a synovial membrane?"

"What is the nerve-supply of the tensor tympani, and from which cranial nerve does it come?"

"What is its action?"

"Is the process voluntary or reflex?"

"What other passages for vibratory stimuli are there besides the membrane and ossicles?"

"What is the communication of the cochlea with the vestibule, and with which part of the latter?"

"What communicates with the utricle?"

"How does the auditory nerve end in the semicircular canals?"

"Are the hairs in the cells longer than those on the rods of Corti?"

("Well, you have not noticed it. All right.")

"Will you draw me a blood-pressure curve?"

"Where do the two phases of respiration come in?"

"Yes; but in your diagrams there are a greater number of heart beats in expiration: is that correct?"

"What would be the effect of stimulating the depressor nerve or the distal end of the divided vagus at certain defined spots on tracing? Draw the effect."

"What is the effect of stimulation of the glosso-pharyngeal on respiration?"

"For how many respirations would the inhibition last?"

"Are capillaries of constant calibre?"

"What causes their dilatation—and you say the state of the arterioles determines the peripheral resistance?"

"Yes; and how you could vary their calibre."

"Why do dilated capillaries contract when the corresponding arterioles are constricted after active dilatation. You don't know? Well, it isn't a point of much importance."

"What is your temperature?"

"Within how much does it vary in health?"

"What would be the effect on it, if going into a room at 140° F.?"

"Would the rise be due to, or accompanied, by increased heat production and loss?"

"What goes on in this relation, in a vapour bath?"

"Yes, there is no increased, but greatly diminished heat loss."

"Oh! you say the heat production would be greater (slightly). No, I should say it would be decreased.

(Bell). F.

Pass List.

Royal College of Surgeons England, May, 1894.

FIRST FELLOWSHIP EXAMINATION.

Bell, H. T. S.	Hancock, W. I.
Butler, A. G.	Leete, A. H.
Collins, V. E.	Plummer, W. E.
Fagge, C. H.	Shillitoe, A.

Stevens, T. G.

L.D.S. EXAMINATION.

Allworth, A. L.	Jones, G. Willcox
Constant, F. C.	Musgrave, L. G.
Davison, T. S.	Pare, J. W.
Hills, W. E.	Pilcher, W. H.
Henry, P. F.	Thornton, R.
Huckle, A. H. H.	Tyrrell, A. J.

Willis, G. N.

University of Durham, April, 1894.

RECOMMENDED FOR THE DEGREE OF DOCTOR IN MEDICINE FOR PRACTITIONERS OF FIFTEEN YEARS' STANDING.

Chadwick, G. R., M.R.C.S., L.S.A.

FINAL EXAMINATION FOR THE DEGREES OF BACHELOR IN MEDICINE, AND BACHELOR IN SURGERY.

Miller, W. F. Zumbado, F.

Royal College of Surgeons Ireland, May, 1894.

L.D.S. EXAMINATION.

Stoker, F. O.

Immunity.

A Paper read before the Physical Society, March 3rd, 1894, by Mr. E. A. PETERS.

(Continued.)

The acid injected causes slight fever and fatty degeneration of the heart. It is noticeable that the difference between the action of the albumose and the organic acids is rather one of degree than of kind. On analysis of the diphtheritic membrane, it was found to consist of fibrin, hetero-albumose with a little dentero- and proto-albumoses; a little of the acid described above was also present. These albumoses were much more powerful poisons than the albumoses derived from the tissues, and when injected into an animal they produced a local slough. From the excess of hetero-albumose it is supposed that in the membrane is the commencement of the process, while the final products are absorbed into the tissues. The varying virulence of these albumoses is a proof of the presence of a body of ferment character bound up with these substances. Colonies of diphtheritic bacilli readily lose their virulence, which is not readily regained. Virulent and non-virulent colonies may be observed living together.

Immunity has been attained in the case of animals by the use of iodine trichloride. It has been shown that animals cannot tolerate even minute doses of diphtheritic poison, though rats' serum will readily cause the death of any bacilli injected. The poison is, however, unaffected by the serum. However, Kitasato found that the blood serum of an immune rabbit destroys the toxin, and so is said to contain an antitoxin. There is some clinical promise in these experiments.

No facts with foot and mouth disease are known which throw light on the subject.

Small-pox is very interesting with its chemical relation to vaccination. The specific cause of the disease, whatever it is, enters by the respiratory or alimentary tracts. Human beings are rendered immune by vaccination from pox vesicles, which are prevalent among cows, and were first described by Jenner. A cow has been infected by human small-pox in at least two cases, and after a few generations of transmission to calves the fluid from the pustules produces typical vaccination in children. The vaccination pustule is of similar structure to the small-pox lesions, and it is supposed that infection by an attenuated virus confers immunity, which bears a close proportion to the amount of local lesion, and to the repetition of the modified disease. The modification is so well marked that degrees which bear a ratio to the foveation are found.

In slightly modified cases the eruption ceases at the pustular stage. In the other degrees the vesicular or papular stages are reached, while violent pains in the back without a rash have been ascribed to a slight attack of modified small-pox.

The lymph is a clear fluid mixed with a little opaque material, which is of peculiar importance in vaccination according to some authorities. It usually contains a large number of germs, especially those specimens which have been kept some time and have not been diluted with glycerine. Klein has even found the streptococcus of erysipelas in one specimen. Experiments show that it is the particulate portion which is efficacious. However, more recent experiments (Copeman) show that in filtering some of the soluble substances may be removed. Copeman finds that the micro-organisms do not grow the lymph is exposed to a temperature between 38° and 42° C., and no growth takes place. Accordingly, the action of the lymph is not due to an organism which grows under these conditions. Some of the lymph exposed to 48° C. for an hour was inoculated into a calf, no vesiculation followed. The calf was immune against vaccination with ordinary untreated lymph. Copeman suggests that vaccination may therefore be carried out in this way so that the vesiculation is avoided. He also shows that lymph without the usual micro-organisms is more efficient than the usual lymph. For the inoculated calf which was not infected with ordinary lymph gave five vesicles on treatment with the lymph kept at 38°–42° C.

In scarlet fever the most striking fact to hand is the greater susceptibility of the young in direct proportion to their youth. It is probably true that the Eberth Gaffky bacillus is the specific cause of typhoid fever; but it is not absolutely proved to be so. It is found in the stools, in the inflamed Peyer's patches, and spleen of typhoid patients. The bacilli do not appear till the eighth day of illness. Typhoid has not been reproduced in animals. Fränkel injected rabbits with it; a large dose produced septic infection. A small dose was found to render rabbits immune against a larger dose. White mice are very susceptible. With regard to immunity caused by small doses of virus, it is noteworthy in the French army statistics that, in a regiment composed of recruits from town and country, those from districts in which typhoid was rife, were less afflicted with the disease. There are numerous micro-organisms present in typhoid. Babes has isolated nineteen species. It is doubtful if the symptoms are caused by a bacterial poison. The virulence of typhoid virus is peculiar. The stools do not acquire their full virulence for some time. In soil deposits as well it is a considerable time before virulence is established. Infection is probably only effected by means of the alimentary canal. Interaction with other organisms has been suggested. Relapsing fever is of interest on account of the phagocytosis obtaining. In the case of monkeys there is no recurrence, which is ascribed by Metschnikoff to more complete destination by phagocytes than in man.

Cholera, even more than typhoid, depends in some way on a saprophytic existence for its degree of virulence. Thus, in Calcutta it is epidemic from December to July, while it is endemic for the rest of the year. Though a disease of filth, insanitary places lik Rome and Lyons are peculiarly free. It is suggested that something like spore formation in a suitable soil is necessary for prevalence. Again, cholera cultures in animals increase in virulence after a few generations, so that finally every inoculation is fatal.

Exposure to oxygen at 39° C. causes attenuation, and this attenuated virus breeds true. It confers immunity on animals. Koch considers that cholera acts by the production of a chemical poison, and Hueppe has found cadaverine present also. Hueppe finds that the amount varies greatly, being considerable in anærobic growth, *i.e.*, in an egg. A considerable quantity of poison is also produced in serum growths.

It is difficult to infect animals, but Cunningham has obtained choleraic symptoms by suitable treatment. Koch fed animals on human cholera stools, but the vibrios were destroyed by the hydrochloric acid of the stomach. He then injected them into the intestines and blood with no effect. Nor did irritation of the intestine bring about the required result. Sodium carbonate was then used to neutralise the stomach contents, and one animal out of four died apparently with relaxed intestines due to external cause (peritonitis possibly). Koch then used opium to relax the intestines, and infected eighty-five animals with cholera; these animals showed the ordinary cholera pathology. Klein considers the damaged intestine as one cause of infection. There are no spores in the cholera bacillus; this is also the case with typhoid.

Tetanus, again, attacks man as a localized disease, being present in the suppurating wound alone. It produces its fatal effects by its toxic products. These can be filtered off, and are found to be allied to snake poison (Vincent and Vaillard). This poison is destroyed or neutralized if the blood serum of an immune animal is added to it.

Attenuated virus is formed by growing tetanus on thymus, which is then injected into an animal, and immunity results. This is supposed to be due to the action of the chemical products. If an animal is injected with a virulent culture and later with immune serum, then the animal recovers. The substance to which we owe this action is called an anti-toxin, while the poison is called a toxin.

Tizzoni and Cattani have used this method with success in man. While recently, in Leicester Hospital, a case with developing symptoms of tetanus was cured by the injection of serum from an immunised animal.

According to Metschnikoff's view, this is due to the accommodation of the mesoplastic cells to the tetanus poison, so that they are not paralysed by the toxin.

Glanders is an example of a disease, common in animals till quite recently, which occasionally attacks man after contact infection. The bacilli are very similar to tubercle in appearance, and an extract of the bacilli —mallein—produces a diagnostic rise of temperature in glandered cases in a similar way to the action of tuberculin.

A large amount is known as to the immunity conferred by a single attack of syphilis against subsequent infection. Another attack with secondary sequelæ is very rare, while recurrent chancres are rare and do not usually present so much structural change as in the first attack. There seem to be individuals liable to two attacks of several diseases, an attack of which generally confers immunity to the ordinary individual.

In the congenital form of the disease, Berry Haycraft calls attention to the acute infective type and the non-infective, which prevent the constitutional results of disease, and often causes death by marasmus. The first would seem to be a matter of infection, while the second, rather a degenerate development.

The specific cause of rabies is of unknown character; it cannot be artificially cultivated, but it is found especially virulent in the central nervous system, and saliva of the affected animals. Wolves and dogs are normally subject to this disease, while man is frequently infected by bites from the enraged animals. Great success has attended the Pasteurian treatment, mortality being reduced from, at all events, 12–14 per cent. to 0·95 per cent.

Briefly, the system is as follows:—The cords of rabbits, dead of inoculated rabies, are exposed over caustic potash to a temperature of 23° centigrade, for periods up to fourteen days. Emulsion of these cords are then made. Beginning with the fourteen days cords, the emulsion is injected into the flank of patients. Later, cords which have been exposed a shorter time to the attenuating influence, and therefore more virulent, are inoculated. The strongest virus used is from a two or three day cord. The treatment extends over two or three weeks, according to the severity of the case.

The constituents of the attenuated virus are peculiar. Pasteur considers it to contain (*a*) living vaccinating substance; (*b*) a chemically potent substance. A large amount of the non-virulent virus injected into a rabbit, causes death as if virulent virus had been injected. The immunity conferred upon dogs which have undergone inoculation, even of the virulent cord, lasts for three years. Cases of men and dogs, in which symptoms of rabies have appeared, have made a good recovery on treatment. Some cases of death are probably due to disappearance of immunity before the rabies virus has left the system (Roux).

The poison which brings about the fatal effect is soluble in glycerine, and resembles an enzyme. It produces an amount of disease in rabbits proportionate to the quantity injected. However, it confers no immunity on the inoculated animal.

Serum of frogs, which are immune under any condition, and that of immune dogs destroy the poison in 5–6 hours.

The virus of rabies is attenuated by culture in the frog's lymph sac, while frogs' albumoses bring about some slight immunity in dogs.

Hence in rabies we see that immunity is brought about by a species of vaccination, while the virus causes its fatal effects by means of toxic products. These products are soon killed by the serum of immune animals. *(To be concluded.)*

Sport.

Cricket.

GUY'S v. BECKENHAM.

Played at Beckenham, Saturday, May 5th. Unfortunately for us several of our best bats and bowlers were prevented by the calls of work from helping to repeat last year's victory, though we were glad to see that one of them was able to get away in time for dinner. Francis won the toss, and naturally elected to go in, as the wicket, as usual on the Beckenham ground, was perfection. He and Nicholls opened our account, but the former was caught with the total at 12. Reid followed, and Nicholls scored three fours off successive balls from Baker, who was not in great form, owing to a strain. Reid was soon caught at the wicket for 2, the second wicket falling at 29, and Wilson came in, and with Nicholls effected a useful stand which realised 40 runs; but at 69, Nicholls, in trying to pull a short ball from Layman, was caught for a hard hit 43, in which were eight fours. Ham followed, but did not stay long, being clean bowled by Lee—four for 81—and Wilson soon after fell to Layman for a good steady 21. Pike and Simson added 20, bringing the total to 115. Alexander and Pike now got together and played excellently, adding 35 for the seventh wicket, when Pike was stumped smartly by Gay for a very useful 27. The next four men, two of whom came to our assistance at the last moment, added but one run between them, and the total only reached 151—not a great many on so good a wicket. Alexander carried out his bat for a careful 17.

Beckenham began their innings with Cooper and Stenning, and the weakness of our attack was very soon apparent. The pair put on 86 for the first wicket, which was not very encouraging for us. However, things went better for a time, and five wickets were down for 146. Cooper played a splendid innings of 73, and seems to be rather partial to our bowling. Inglis and Gulliver hit out freely, and the score rose at a tremendous pace, Inglis in one over hit Nicholls for 22—two sixes, two fours, and a two; it must be said that the wicket was rather near the boundary, otherwise there would have been four good chances of his being caught in the country. These two added 82 for the sixth wicket. Layman did not give much trouble, but A. A. Baker played steadily, while Inglis went on hitting, and helped to add 77 more for the eighth wicket, when Inglis was finely caught by Wilson in the country for a slashing 132, in which were two sixes and twenty fours—eight for 310. The ninth wicket put on 31 more, and the innings closed for 344, Beckenham thus winning by 193 runs. Seven bowlers were tried, but Pike's was the only analysis worth mentioning (three for 17); Reid (three for 88) bowled well when he went on the second time, but his analysis was spoiled by the expensiveness of his first and third efforts. The fielding, on the whole, was good, and Loud's wicket-

keeping pads were most successful; only eight byes in a total of 344 speaks for itself. Several of the team were very kindly entertained during the evening by Mr. Layman. Score:

GUY'S.

C. J. Francis, c Sub. b A. A. Baker	8
F. J. Nicholls, c Inglis, b Layman	43
E. Reid, c Layman, b A. A. Baker	2
F. E. Wilson, b Layman	21
B. B. Ham, b W. B. Baker	3
N. H. Pike, st Gay, b Edwards	27
H. Simson, c Layman, b Stenning	9
K. B. Alexander, not out	17
H. P. W. Barrow, b Edwards	0
F. Loud, b Lee	1
F. T. Steward, b Lee	0
Extras	20
Total	151

BECKENHAM.

C. O. Cooper, st Loud, b Reid	73
J. K. Stenning, run out	37
F. M. Lee, b Ham	2
L. H. Gay, b Reid	10
L. Hinton, b Reid	12
G. J. Gulliver, b Ham	31
A. M. Inglis, c Wilson, b Pike	132
S. G. Layman, c Stewart, b Nicholls	4
A. A. Baker, b Pike	16
E. R. Edwards, not out	18
W. B. Baker, st Loud, b Pike	0
Extras	9
Total	344

GUY'S v. CRYSTAL PALACE.

Thursday, May 10th. Played on a cold and wet day. Much difficulty was experienced in getting a team together, indeed we were two short until after lunch. Francis lost the toss, and Crystal Palace went in. Their first two men put on 66 for the first wicket, but after them very little resistance was offered to the bowling of Harris and Reid, and the total only reached 138. Then the rain came down and put a stop to the game. Score:

CRYSTAL PALACE.

F. C. Barchard, c Pike, b Reid	30
S. Colman, c Lond, b Reid	35
F. D. Pawle, b Harris	4
G. Bicknell, c Lond, b Harris	3
A. Cousins, c Reid, b Harris	18
Capt. Flemming, b Harris	8
W. F. Umney, lbw, b Reid	10
E. G. Turner, b Reid	4
H. W. Dillon, b Harris	3
A. W. Gardner Woolloton, not out	8
G. W. Stone, b Wetherall	8
Extras	7
Total	138

GUY'S v. REPTON SCHOOL.

Played Friday and Saturday, 18th and 19th May. This time only nine men could be induced to play, of whom one did not turn up at all, and no one knew what had become of him, so we had to borrow three of the Repton boys to play for us. And very useful they were, for they all made runs and fielded excellently. Friday was fairly comfortable for cricket, as the sun made things cheerful, but Saturday was unutterably horrible, a biting east wind blowing all the time, and making things as unpleasant as possible. Francis won the toss and went in, Nicholls accompanying him; the latter was soon disposed of for a single. Perks followed, and he and Francis set to with a will, and aided by some luck put on 81 for the second wicket, when Francis was bowled for a good 44. Joyce and Perks continued the run-getting and kept the field busy, but after 44 more had been put on Perks was bowled for an excellent 55. Joyce was eighth out for a hard hit 65, which included nine fours. The total reached 219 by means of smaller contributions from everyone.

Repton opened their batting with Marshall and Lee, the former of whom was too eager, and was deceived by Joyce with a slow one. Lee and Veal offered a protracted resistance, and the cricket became of the slowest description; between them they added over 100 runs for the second wicket; Eccles, their captain, made things much more lively, and hit freely, while Veal still played carefully. The last six batsmen only compiled nine runs between them; but their total was 15 runs ahead of ours. Joyce bowled very well, but his luck was poor; Pike had the best analysis, four wickets for 19 runs. Perk's fielding was beautiful, and was quite a feature of the match. In our second innings everyone, by some unexpressed agreement, went in and hit, but Francis was the only one who was successful, as he scored 42 out of a total of 101, hitting seven fours. Our three substitutes played up well, and added 24 between them. Only one wicket was clean bowled, all the rest were caught, the boys showing a very marked improvement in this department on their form of the previous day. This left them 86 to get to win, with just under an hour for play; they seemed to have hoped to get the runs, but only managed to get 29 of them for the loss of two of their best bats. Score:—

GUY'S.

	1ST INNINGS.		2ND INNINGS.	
C. J. Francis, b Cochrane	44	c Veal b Curgenven	...	42
F. J. Nicholls c & b Burnett Stuart	1	c Bryant b Curgenven		0
A. Perks b Curgenven	55	c Cochrane b Eccles	...	3
J. H. Joyce b Eccles	65	c Cochrane b Curgenven		0
N. H. Pike c & b Eccles	8	c Veal b Vickers		6
P. C. Prince b Eccles	14	c Burnett Stuart b Curgenven		4
K. B. Alexander b Curgenven	4	c & b Cochrane		7
H. Hewetson c Burnett Stuart, b Curgenven	4	c Bryant b Vickers	...	10

W. F. Adams b Curgenven	0	b Dyer	13
E. Farrar b Eccles	7	c Dyer b Cochrane	7
S. Galloway not out	7	not out	4
Extras	10	Extras	5
Total	219	Total	101

REPTON.

1ST INNINGS.		2ND INNINGS.	
S. W. Marshall c Prince, b Joyce	16	run out	5
F. Lee c & b Nicholls	35		
C. L. Veal c Farrar, b Joyce	74	not out	7
A. Eccles b Joyce	56	not out	7
F. H. Bryant, lbw, b Pike	18	b Joyce	5
H. Vickers c Joyce, b Pike	1		
L. Dyer c & b Joyce	1		
F. J. Cattley b Pike	3		
E. E. Burnett Stuart run out	4		
W. C. Curgenven b Pike	0		
C. W. Cochrane, not out	0		
Extras	26	Extras	5
Total	234	Total	29

Our best thanks are due to the Masters who kindly entertained us on Friday night.

Guy's Hospital Lawn Tennis Club.

GUY'S II. v. WALTHAMSTOW.

The first Tennis match was played at Honor Oak on Saturday 19th, when we gained an easy victory by 8 to 1.

SINGLES.

1. A. V. Clarke b G. E. May, 6–2, 8–6. 2. Partridge b L. Ridgers, 6–4, 6–1. 3. T. J. A. Tulk-Hart lost to R. Ridgers, 7–9 ,6–8. 4. F. W. Goldie b S. Barker, 6–2, 7–5. 5. E. R. Tebbitt b H. Ridgers, 6–1, 6–4. 6. Fothergill b A. Padfield, 6–1, 6–4.

It was not our good play which won so easily. Our men will have to play up considerably before the cup matches if they wish to regain last year's loss. T. J. A. Tulk-Hart lost his single by playing back too much, R. Ridgers winning by persistently returning his drives until one happened to be driven into the net.

DOUBLES.

1. Partridge and Clarke b May and R. Ridgers, 6–4, 6–2. 2. Tulk-Hart and Goldie b L. Ridgers and S. Ridgers, 5–7, 7–5, 6–4. 3. Fothergill and Tebbitt b Padfield and H. Ridgers, 6–2, 4–6, 8–6.

The reason, no doubt, that the two last couples lost a sett each, lay in the fact that they played together for the first time.

G. B. W.

Guy's Hospital "Blue."

AT a meeting of the "Blues" Committee held on Thursday, May 17th, the following Past and Present Students were awarded their "Blue" for representing the Hospital in Inter-Hospital Competitions:—

FOOTBALL.

ASSOCIATION.—PAST.

Browne, Robley H. J. — Kirkby, R. C.
Hazell, F. — Mumford, W. G.
Hunt, E. — Sturges-Jones, W. E.
Woodhams, S.

PRESENT.

Carter, A. B — Cooper, N. C.
Walker, F. E.

RUGBY.—PAST.

Burrell, L. C. — Rygate, H. B.
Humphreys, R. — Randell, R. M. H.
Hickman, H. V. — Salvage, J. V.
Jewell, W. H. — Wallis, S. S.

PRESENT.

Mathias, R. — Tyson, W.
Stoker, F. O. — Wetherell, F. C.

ATHLETICS.—PAST.

Coleman, Owen. — Hickman, H. V.

CRICKET.—PAST.

Lucas, C. R.

FOR TENNIS (SEASON, 1893).

Clarke, A. V.

Gentlemen before ordering their Blue, coat, badge, etc., must first obtain a written order from Dr. Shaw, without which Lewin is not allowed to supply them.

H. HEWETSON,
Hon. Sec. "Blues" Committee.

Guy's Hospital Rifle Association.

GUY'S v. CHARING CROSS.

THE first match of the season, against Charing Cross, terminated in favour of Guy's by sixty-eight points. Shooting commenced at 200 yards about 2 p.m., in good steady light, though dull, and we went back to 500 leading by three points. Here, owing to the excellent shooting of Sells and Telling, we increased our lead to sixty-five. On getting back to 600 the wind was very tricky, and there was a smart shower on beginning; this cleared, but the light remained bad, and possibly accounted for the falling off of the team, only one twenty being scored. However, Charing Cross were in a similar condition, and a further lead of three points was gained, making a total of sixty-eight.

	GUY'S. 200	500	600	TOTAL.
C. B. Sells ...	23	32	18	73
R. H. Ashwin ...	27	24	19	70
S. H. Mason ...	13	14	11	38
H. Fulham-Turner	25	25	9	59
W. H. M. Telling...	24	31	22	77
		Aggregate	...	317

	CHARING CROSS. 200	500	600	TOTAL.
A. E. Street ...	20	10	14	44
N. P. King ...	16	2	9	27
A. E. Walker ...	22	23	26	71
A. H. Parker ...	25	9	8	42
L. Lloyd ...	26	20	19	65
		Aggregate	...	249

GUY'S v. ST. MARY'S.

This match was shot at Ilford, on Tuesday, May 22nd. We were, unfortunately, without the services of Luce or Fulham-Turner, and were beaten by the narrow majority of seven points. The match was between teams of four men, at the ranges of 200 and 500 yards; at the 200 range, shooting was good, Staples, of Mary's, putting in an excellent thirty. On going back to the 500 range, Guy's were leading by four points; but at that range the shooting of both teams fell all to pieces, the only man who made anything like a respectable score being Wells, of Mary's, with twenty-four, and he lost five points by putting a bull's-eye on the wrong target; the rest were uniformly bad. There was some excuse for the bad shooting at 500 yards, as it was a bitterly cold day; the light was dull, and there was a very gusty wind blowing right across the range. Scores:—

	GUY'S. 200	500	TOTAL.
C. B. Sells	23	15	38
A. Scott-Turner	27	11	38
W. H. M. Telling	27	15	42
R. H. Ashwin	29	16	45
	Grand total	...	163

	ST. MARY'S. 200	500	TOTAL.
Wells	21	24	45
Staples	30	11	41
Hammond	28	16	44
Mason	23	17	40
	Grand total	...	170

Appointment.

GROVE, W. R., M.D. St. And., M.R.C.S. Eng., has been re-appointed Medical Officer of Health for St. Ives, Hunts.

"Artists" Rifle Volunteers.

MEMBERS are reminded that the Annual Inspection will take place on Saturday, June 9th. Parade at University College at 3.15 p.m. Marching order. Haversacks empty and rolled up. No capes. For Hyde Park. Men are urged to wear strong boots on this occasion, as last year the Inspecting Officer found fault with the boots of two men. Those possessing ammunition boots should wear them. Button boots must on no account be worn.

Every member must be present at the Inspection, unless leave of absence has been obtained, in writing, from the Colonel commanding, and in no case will this be granted, except in case of urgent private affairs or sickness. In the latter case a medical certificate must accompany the application for leave of absence. Applications should be made through the Captain.

There will be an extra Battalion Drill on Saturday, June 2nd. Parade at Somerset House 3.45 p.m. Full marching order. For Wimbledon.

The Artists' Bayonet Display (100 men), at the Royal Military Tournament, will be on the evening of June 4th.

A PRACTICAL MAGISTRATE.—A rather amusing incident occurred at the Faversham County Police-court the other day. A stranger, who gave the name of Thomas Jones, pleaded guilty to a charge of refusing to perform his task of work while an inmate of the Union Workhouse, but he told a pathetic story of a weak heart, "which wouldn't beat" occasionally. The magistrate happened to be Dr. J. Irvine Boswell (a Guy's man, by-the-way) who was only recently appointed. He heard the man's story, and then left his seat and advanced to prisoner and felt his pulse. Next he caused him to bare his chest, and there and then applied his stethoscope, after which he said the fellow had told a story. There was nothing wrong with his heart. The prisoner protested, but all the reply he got from the expert magistrate was "You will have seven days' hard labour."

PRESENTATION.—Mr. John Augustus Ball, M.B. Lond., M.R.C.S., of Wantage, Berks, has been presented with a massive silver salver, accompanied by a handsomely framed illuminated list of subscribers. The salver bears the following inscription: "Presented to Mr. J. A. and Mrs. Ball, by friends, as a farewell gift on leaving Wantage."

Death.

STOCKER.—On the 7th May, at Easton, Winchester, Isabella Avarilla Stocker, daughter of the late Richard Stocker, of Guy's Hospital, in her 84th year.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor*, Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

JUNE 9, 1894.

Aortic Incompetence.

CLINICAL LECTURE BY DR. NEWTON PITT.

ALFRED W., æt. 21. A potman, with a history of four attacks of acute rheumatism with arthritis, the last being in March. In April he complained of breathlessness on exertion, cough, loss of appetite, and insomnia.

Admitted with acute pericarditis, pyrexia, rapid pulse, 115, splashing in character. Diastolic bruit traceable down the sternum towards the apex, and a systolic down the sternum. At the apex there is a presystolic thrill and a less definite bruit. There are an impaired note and respiratory sounds at the left base.

After a month the pericarditis quiesced, but the muscle began to yield, and he became more markedly œdematous. The evidences of mitral stenosis, which had become obscure, again became more obvious.

The condition was essentially one of aortic incompetence, the mitral stenosis being moderate in amount, judging from the character of the pulse.

In thirteen out of thirty-nine cases of these combined lesions no presystolic bruit was audible; and with marked mitral stenosis a slight failure of the aortic valves will also probably be unsuspected.

Cases of aortic incompetence generally take one of two courses; there are either anginal attacks of pain, with liability to fainting and on exertion probably instantaneous death; or the heart dilates, and the patient developes evidence of venous engorgement with œdema, with or without mitral incompetence. The two groups are quite distinct, and each case must be treated accordingly.

The abnormal sounds audible when the aortic valves are incompetent are either a diastolic bruit, or a to and fro bruit, replacing or supplementing the second sound. Merely the presence of a systolic bruit is not sufficient to justify a diagnosis of stenosis, as it is often produced by a tense edge or an irregularity on one of the cusps, or by an atheromatous rough surface on the aorta itself. This latter, and not aortic stenosis, is the explanation of the rough basic systolic bruits unaccompanied by any diastolic, which are sometimes audible in men after middle life.

The diastolic bruit, which is often of a blowing character, like the sound "too" may also be musical, rough, or sawing in character; it may be barely audible, or may be so loud as to be heard across a distance of a foot or more away. The length also varies with the amount of incompetence.

The bruit is audible at the level of the third cartilage, and may, when the leakage is moderate and the compensation sufficient, only be traceable down the sternum and slightly to the left, and usually also up to the right second space. When the heart is dilated, and the accommodation insufficient, the bruit is traceable further towards the apex, and when the leakage is very great the bruit may also be heard in the main arteries.

Occasionally the bruit is only audible at the apex; it has been suggested that in these cases the vibration has been transmitted by the aortic cusp of the mitral, and hence arises when the right posterior cusp has failed and allowed the regurgitant stream to impinge on this flap.

The systolic bruit is best heard at the level of the third cartilage, especially on the right side, and is more definitely transmitted up to the right clavicle in the atheromatous than in the rheumatic cases.

Diastolic bruits arise from incompetence due to:—

(*a*) Shrinkage of the valves from rheumatic endocarditis.

(*b*) From atheroma, which often has spread from the aorta, and is associated with chronic Bright's disease, gout, syphilis, malaria, etc.

(*c*) From the dilatation of the aorta, while the valves remain healthy.

(*d*) Vegetations on the valves.

(*e*) Fungating vegetations.

(*f*) Ruptured valve from sudden strain.

(*g*) Temporary dilatation of the aorta, which disappears under treatment.

A to and fro bruit is usually audible with (*b*), (*e*) and (*f*), and not infrequently with (*a*).

These may be differentiated by the following considerations:—

(*a.*) Young patients, history of rheumatism, often no systolic bruit, when present less frequently transmitted up to the clavicle. Bounding, visible carotid pulse with a thrill and marked pallor. The lesion constitutes the disease.

(*b.*) Age 40 to 50, history of some cause producing atheroma, usually a to and fro bruit, often harsh or musical. The arteries are atheromatous and less bounding; the degeneration dominates the lesion.

(*c.*) This occurs in about five per cent. of thoracic aneurysms, viz., in those which involve the first two

inches of the aorta, and in fusiform dilatations of the ascending arch, when the associated attacks of cardiac dyspnœa, and angina, with episternal pulsation, may often suggest this.

(*d.*) A very short diastolic bruit appearing with acute rheumatism, which after a few weeks may disappear or be replaced by the longer or more definite bruit of (*a.*)

(*e.*) The prostration, marked anæmia, petechiæ, and general toxic condition with pyrexia and a markedly dicrotic pulse and soft bruits varying under observation are generally sufficient.

(*f.*) The sudden onset after exertion, and the dyspnœa, pain, and great cardiac failure are characteristic.

The amount of incompetence may be estimated by considering:—

The size of the heart.

The length of the diastolic bruit.

The degree of the capillary pulsation.

The amount of anæmia.

The movements of the arteries and the characters of the pulse-tracing, *e.g.*

A lofty up stroke with a sudden fall and an empty vessel during diastole, the absence of a dicrotic wave, and ready obliteration of the characters of the pulse by a low pressure indicate marked incompetence.

A tracing with a wave in the up stroke, *i.e.*, an anacrotic tracing, with a moderate up stroke, indicates increased peripheral resistance or obstruction at the orifice.

A tracing, when compensation is good and the incompetence moderate, may be fairly normal, although the pulse may have a water-hammer character.

The presence of albuminuria may indicate very low arterial pressure and great incompetence.

Prognosis is founded upon the following factors:—

Age.—Much more favourable when young than after middle age. Dr. Fowler has reported the case of a man, æt. 66, who fifty-four years previously had been under Sir Thomas Watson with aortic disease and pericarditis. A loud bruit, like the whistling of a steam engine, was then heard; this was still present, but the man had remained in good health and able to work hard always.

In a case recently under observation, there was evidence that the man had had aortic incompetence for twenty-eight years.

Exposure, intemperance, dissipation, starvation, and a very laborious occupation, make the future much more unfavourable.

With atheroma the valvular lesion is progressive, and muscular degeneration is readily induced by the defective condition of the coronary arteries. Hence *cæteris paribus* the prognosis is much worse than in rheumatic cases.

The amount of incompetence.—Where this is great the downhill course is rapid; in extreme cases the patient has only survived the onset of the symptoms two weeks. The average duration of the fatal cases in the Hospital was four and a half years.

The cases with anginal symptoms are especially liable to sudden death. Out of thirty-four sudden deaths, thirteen were due to aortic incompetence, and seven mitral stenosis. Any violent exertion, and when it may occur can never be foreseen, may terminate life instantly. The œdematous cases generally die out more gradually. Visceral disease, or a failure of general nutrition, act most injuriously.

Lastly, and by no means the least important, is the patient's temperament and disposition. An excitable irrascible temper is unfavourable.

Treatment.—After an attack of acute endocarditis prolonged rest and quietude is of importance, but afterwards, if there is satisfactory compensation, the patient should lead a quiet and equable life, and never hurry or undergo any violent exertion rather than keep absolutely laid up as a useless member of society.

Periodic attacks of digestive failure occur, especially in the atheromatous cases after middle age, which require blue pill, calomel, and salines, and benefit markedly.

Insomnia, cardiac pain, and distressing attacks of dyspnœa, sometimes yield to morphia, while belladonna and diffusible stimulants are also of great value.

Rest, as far as possible in the recumbent position, with careful dieting are essential where there is marked cardiac failure, while the anginal attacks call for nitroglycerine, nitrites, and when there is great peripheral resistance with feeble driving power, for venesection.

Opinions differ as to the value of Digitalis in these cases. There can be but little doubt that it may be absolutely injurious in the anginal cases, while I believe it is equally called for in some of the œdematous cases.

Small doses of Iodide of Potassium over considerable periods, greatly benefits cases with atheroma and but little incompetence.

Where the incompetence is extreme it is necessary to insist upon the avoidance of any exertion, however small, and drugs will be but of slight avail in prolonging life for more than a short period.

A Localised Swelling on the Ulna.

CLINICAL LECTURE BY MR. SYMONDS.

THIS lad, Gentlemen, whom I have brought here to-day for your observation, is sixteen years old, and presents, as you see, a swelling in the lower third of the forearm. On a closer examination, we note that it is attached to the ulna, and that though involving the lower end, the joints are both free. The swelling is, moreover, hard and painless, and passes imperceptibly into the bone above. In examining a swelling for its connection with a bone in a limb, be careful to make your test in the axis of the bone, not across the bone. A swelling loosely attached may give movement when manipulated laterally, but not when an attempt is made to move it in a line parallel with the limb. Note again that you must not test for fluctuation across a muscle, especially in the limbs, for the elastic sense yielded by the structure may

very likely deceive you—*fluctuate in the line of a muscle.* Similarly, in detecting the adhesion of a carcinoma of the breast to the pectoralis major, you may find when the arm is at the side, the tumour moves in all directions over the underlying muscle; raise the arm up by the side of the head, and put the pectoral on the stretch and then examine. The tumour will still move over the muscle or with it, from side to side, but is found to be fixed when it is manipulated in a line parallel with the fibres. When in my out-patient room, I ask you to test the connection of a mammary tumour to the muscle, I do not always see this method employed, and therefore I mention it. Once more, fluctuate the knee in a line with the limb, not across, if you want to detect the presence of a small quantity of fluid. Examined in this way then, we find the swelling is solid, and we may speak of it as a *chronic localised swelling* of a long bone. It is under this heading I wish to put the case before you to-day, and my object is to discuss with you the various causes leading to the foundation of such a condition.

I give you the following conditions or causes that may lead to the formation of a chronic localised swelling in a bone.

I.—A DEPOSIT OF INFLAMMATORY NEW MATERIAL in the periosteum, *i.e.*, a growth of granulation tissue. This may be due to, and so far as long bones are concerned, is nearly always due to syphilis, either acquired or hereditary. A deposit of tubercle will also give rise to this condition, but you will note that, in the form of a localised swelling it is rare, except in the phalanges and metacarpus. Here, in children, it is very common, and you know it under the title of "Strumous Dactylitis." The third cause of an inflammatory origin I would give is that due to a central necrosis. This, apart from tubercle, is certainly very uncommon indeed, for it is almost true to say, that all chronic and central abscesses in bone, with or without a sequestrum, is due to this cause. I have one specimen, however, of a central abscess in the lower end of the tibia, following an injury five years before, and a microscopic examination of the pyogenic membrane lining the cavity, shows it to be of a simple non-tuberculous kind. Will injury in any other way give rise to a chronic localised swelling? When I asked this question a couple of weeks ago over this lad at out-patients—indeed, whenever I do so, the first reply I usually receive is that it may be due to injury. Now, if you examine the cases, I think you will agree with me that injury in healthy people, apart from a fracture of the bone, never produces a localised periostitis of a chronic kind. There may be extravasation of blood and attendant swelling, but this is acute. There may be a fracture undetected at the time, and a patient who may come a year after to you, says that the swelling followed a blow, but that there had been no fracture.

The most striking case of this was one I remember under Mr. Howse, many years ago, of a young man of twenty—just the age for sarcoma—with a swelling of the lower third of the tibia, without history. It was thought to be a sarcoma, though doubtfully so, and it did not yield to remedies. He was prepared for exploration, when a history of injury was obtained from a friend. The swelling entirely disappeared. It is quite possible for a man to have his tibia broken and walk. He may be drunk at the time of the accident, or it may be one of several injuries and so be overlooked. It is conceivable, as Billroth points out, that in old and feeble people a chronic periostitis may follow an injury. Still, when an injury does produce chronic periostitis, you will find there is almost always and, so far as I have seen, always an underlying dyscrasia, such as syphilis, tubercle, or gout.

Amongst the causes leading to an inflammatory swelling we must note the presence of actinomycosis. This especially in the lower jaw. Rheumatism will, as you know, produce small nodosities. They are, so far as I have seen them, multiple, and on the exposed edges of bone, such as the shin and skull.

Finally, we may say that the localised swelling due to the formation of an inflammatory new deposit is nearly always syphilitic, when occurring in shafts of long bones and in the skull. That in the smaller bones, it may be tubercular, while in the epiphysis it may be due to central ortitis. That this central ortitis, usually tubercular, may occasionally follow an injury. The causes depending on special conditions, such as those found in the jaw, are beside the case before us.

II.—THE SECOND GREAT CAUSE leading to localised chronic swellings is due to the formation of a primary or secondary tumour. I mean fibroma, osteoma sarcoma in the first instance, and carcinoma in the second.

To make this clear, examine this specimen (1117[20]) of a central myeloid sarcoma of the lower end of the radius, and this carcinoma of the shaft of the humerus which was secondary to a primary growth in the breast; or again, this elliptical, node-like swelling in a rib (1050) which was secondary to the breast also. I mention these to you, especially the secondary growths, because a patient may come with a swelling due to such a cause with no complaint of a primary growth. Not long since, I was asked to examine a man with spontaneous fracture of the humerus. It was certainly due to a growth, and I have no doubt the primary formation was in the liver.

Again, I assisted once at an operation in the coracoid process which proved to be invaded by a new growth. The microscopical characters were those of a cylinder epithelioma, and I had no hesitation in expressing the opinion, that the primary growth would be found in the intestine or liver. Some months later, a portion of the liver and gall ducts was sent me containing the primary formation. A former breast case of mine came with a painful "node" on the ulna, exactly like that due to syphilis; moreover, it became a little smaller and less tender under treatment, as you know most carcinomatous deposits will do. Anyone might have been deceived without a history, and, indeed, a homœpath, neglecting history, assured the poor woman he could cure her.

Coming back to the case before us, let us investigate into the cause of this particular swelling. Just above the main enlargement two smaller nodules are to be felt, and we write down the very important fact of *multiplicity* in the same bone. Next examine the *corresponding part in the opposite limb.* We find it normal. Let me impress upon you the value of this clinical axiom. When investigating a case before you, in the out-patients or elsewhere, I am constantly directing your attention to this point, and so do we all, and yet how often is it neglected. You are examining a knee, how can you detect smaller differences without comparing the normal side? Or, again, you discover a symmetrical distribution of disease, and so advance a long way in the diagnosis of the case. Next let us examine *the similar tissue in the body.* In this case the other bones. You see his arms and head are free. But in the right shin we note several scars and an irregularity of the tibia, indicating old disease of the bone here. The left tibia is normal, but you see one large scar near the knee. We again write down multiple lesions, and at once conclude that the ulnar enlargement has a constitutional origin, and in one so young must be due either to syphilis or tubercle.

Let us next examine for *Associated Lesions.* I mean by this, the existence of other and progressive maladies. Remembering the age of the patient, look at the cornea for interstitial keratitis. At present the eyes are free, but up to twenty, as we know, he is liable to this affection. Note that he is deaf, and in both ears, the symmetry, with the absence of any purulent discharge, past or present, suggests congenital syphilis. We also look at the soft palate, where not infrequently we notice extensive destruction. Another position where syphilitic lesions, especially with acquired disease, is overlooked, is in the testes. In the congenital form, testicular affection is less common, but by no means unknown. However, they are most often found in quite young children.

Let us next examine our patient for *evidences of past disease.* In our search for other nodes we found several scars. And here let me remark on the appearance of these scars. There is a scar which is characteristic of syphilis, and that in this shin is an example. Note that there is a group of small, irregular scars, with bands and islands of skin between. Pigmentation I look upon as of little value, for it is absent when congestion is absent. You will not find it in or round the scars on the face, or upper part of the body, and you will note its absence in this scar near the knee, while it exists in this one in the lower part of the leg. This drawing shows you the typical scar, and, at the same time, a progressing ulceration near it. You will see that the skin between the ulcers is red and infiltrated, from which we learn that there is a general infiltration and a syphilitic deposit over a large area; that ulceration takes place at several points, but the intervening infiltration becoming absorbed, the result is that normal, or fairly normal, portions of skin remain.

You will see these scars most often in the acquired form; especially are they prevalent about the lips and chin and face, and also on the back. You will often make a diagnosis by such a scar, and I might relate to you several cases where the most important results turned upon a scar. A very able and experienced friend sent a man to see me, before he removed an epithelioma from the corner of the lip. He had overlooked a very typical scar near to it. Under iodide he recovered. A knee-joint in a man I made out due to syphilis, because of a number of scars on various parts of his body. These he said were due to "blood-poisoning," and in this I concurred. It was a blood-poisoning. I told him no more; why should he know? He gave up his crutches very soon, and is now quite well.

Look next at this upper left *lateral incisor tooth*, and note the notch in the free cutting edge and the rounded corners. It is a very fair specimen of a "Hutchinson" tooth. Here are Mr. Hutchinson's drawings, and you will observe that the upper incisors are the teeth affected. The broad, shallow notch is the characteristic feature, whereas the irregular transverse markings so constantly seen are of no value. Again, as the teeth wear, the appearance disappears, and is seldom of value after thirty. Remember that these appearances are confined to the permanent set.

We have examined, then, first the characters, and the connections of the swelling of the ulna; next, the corresponding part in the opposite limb; then we have searched the other similar tissue in the body — the osseous—for similar lesions; next, we have looked for associated active lesions; and, finally for scars and other evidence of past disease, and we conclude that this swelling is due to syphilis, and of the congenital variety, and that it is a *chronic periostitis.* This node has, as you see from its centre, suppurated. The yellow slough represents necrosing granulation tissue, infiltrating the periostitis and fascia.

Now, it is to be noted, that this node developed while he was under full doses of mercury for extensive ulceration of the dorsum of the foot and ankle, and, unfortunately, you will encounter this occurrence—an incident taxing not only your patient's faith, but sometimes your own trust in remedies. I have no doubt the lad will soon recover, and you shall see the boy again in three weeks, and judge for yourselves.

We will now dismiss the patient and discuss some further points. His deafness has enabled me to speak more fully than I otherwise would have done, for it would be neither kind nor moral, to let him know the cause of all his trouble. This lad has been under my care for ten years off and on, and for the next four years he will require supervision, and probably active treatment.

As I mentioned before, he may still have keratitis and be blind for a time, more or less. After twenty I hope he will be free from these troubles. Then, looking still further ahead, there seems to be no reason why he should not marry, and without fear of transmitting the malady.

These patients, whether male or female, do not appear to transmit any special dyscrasia. I have one woman who was under me before her marriage, and who is now a complete wreck, from the ravages of the congenital disease, and whose children are free from all taint.

Let me, in conclusion, gentlemen, urge the importance of keeping from your patient the knowledge of the syphilitic nature of the malady. I do not think this boy's father and mother have any notion of the cause of their child's disease. There is no object in asking them needless questions, to reveal a secret, the knowledge of which may destroy the happiness of both.

Notes on Dr. Shaw's Demonstrations in Pathology.

HEART.

HEART MUSCLE.

Inflammation.— (1) Simple myocarditis. Difficult to recognise with the naked eye. Microscopically there is loss of striation and presence of leucocytes.

Causes: (1) Rheumatism, generally associated with either pericarditis, endocarditis, or both.

(2) Gonorrhœa ? Possibly this should be regarded as the first stage of a pyæmic myocarditis.

(2) Suppurative. (*a*) Pyæmic (1396[45]) very rare.

(*b*) Ulcerative endocarditis by direct extension (1416[26]), or by infarction of coronary arteries.

(*c*) Tubercle (113).

DEGENERATION OF HEART MUSCLE.

(1) *Fatty* (1400, 851). See also fatty infiltration (1392[20]).—Essentially loss of striation and presence of oil globules in muscular fibres. Found in all cases of heart failure, extreme conditions of anæmia, after prolonged fevers, phosphorus poisoning.

(2) *Fibroid.* — Glistening patches often producing aneurysms; fibrous tissue lies not only between the muscular fibres but actually replaces them.

(*a*) Syphilitic (194). Well-marked gummata are found in heart substances, though a gumma is not necessarily a precursor of fibroid change.

(*b*) Coronary arteries (1396[70]). Fibroid patches often found in connection with atheroma, but both conditions may be due to same cause, *e.g.* syphilis or old age.

(*c*) Myocarditis, found in young people with no history of syphilis but with a history of rheumatism; the fibroid heart found with adherent pericardium is probably due to a myocarditis and not to the pericarditis.

(3) *Pigmentary.* Syn. brown atrophy (1393[10]).—Found under the same conditions as fatty, and very hard to distinguish histologically.

Growth.—(*a*) Secondary deposits: Carcinoma (1399[66]), Sarcoma (1400[25]).

(*b*) Invasion (1400, 226), generally sarcomatous since they begin in mediastinum.

Hydatid (1396[85 & 86]).

Aneurysm.

(*a*) Chronic (1395[30, 31 & 40]) is the result of a local fibroid degeneration of heart muscle; may be multiple, though generally single; varies much in size and shape, a general bulge or a sacculus; in latter case it may spontaneously heal from organization of clot. It is usual to find the pericardium adherent over the aneurysm; this has been regarded as the cause.

(*b*) Acute (1417[16, 30 & 35]) generally occurs in cases of ulcerative endocarditis.

Ruptured heart (1400[71, 75 & 76]) found in cases with degenerated heart muscle.

Lacerated (1400[30, 35 & 56]), generally the auricle.

Wounded.—Gunshot (1400[50]), generally ventricle. Bayonet (1400[66]).

VALVES.

Endocarditis. — Acute rheumatism (1403[30]), chorea (1406[30]), pyæmia (1402[50]). There are three varieties which all run into one another.

(1) Acute (1406[30], 1414[30]) seen in those rare cases in which patients die during an attack of acute rheumatism, also in patients dying of chorea, indicated by a fringe of vegetations on the margin of the valves where they come in contact, distinguished from chronic ones which are harder and more adherent; formerly these vegetations were thought to be lymph deposited from the vessels of the valves, but now held to be deposits of fibrin from the blood bathing them. These may entirely clear up or become chronic.

(2) Chronic (1412[55]), usually preceded by acute endocarditis, but may arise *de novo*, *e.g.* Bright's disease.

(3) Ulcerative Syn. malignant, fungating, (1413[53], 1417[25], 1401[30]), commonly implanted on chronic endocarditis, affects the right side more often than in simple endocarditis.

Clinical features.—High fever, production of septic emboli consisting of detached vegetations.

Atheroma (1418[10], 1452[75], 1411[75]).

Causes: Syphilis; overstrain.

Main feature is to produce calcareous degeneration of valve? The aortic valves are those generally affected. If mitral is affected it produces no defect.

Hospital News.

In the Medical Wards.

CASES UNDER DR. HALE WHITE.

STEPHEN.

30. Sub-hepatic abscess in connection with a very long vermiform appendix. C. W. A., æt. 19. Admitted on May 31st, for pyrexia and pain in epigastrium and right hypochondrium. Patient was a cabinet-maker, and lived in England all his life; he came of a healthy family. Ten years ago he had diphtheria followed by paralysis of muscles of throat and nose; since that time he has complained occasionally of sore throat. Patient enjoyed good health up till last Whit-week. On Monday, May 14th, he was on the river at Oxford, and got wet through; he was able to play tennis on the following day, and go to the theatre in the evening. On the 16th he was taken suddenly ill with a rigor; he was in great abdominal pain, particularly about epigastrium and right hypochondrium, and was very sick, bringing up a quantity of "bile." He has been ill ever since, sometimes having as many as six rigors a day, in which the temperature would reach 104, or higher. There has always been pain over liver and stomach, and occasionally in right iliac fossa. No jaundice, constipation, or diarrhœa. Patient has lost flesh.

On admission.—Temperature 103.6; pulse very rapid and small, abdominal; respiration 26. Patient was collapsed and wore a very anxious expression, sweating considerably. *Tongue* was dark and medicine-stained. There was a slight *erythematous rash* over lower part of chest and abdomen; *abdomen* full, moving slightly on respiration; somewhat fuller over right hypochondrium and part of epigastrium; here there was *pain and tenderness*, and dulness extended half-an-inch below costal margin; *liver dulness* extended above to sixth rib in nipple line, to ninth at angle of scapula, and sloped away to tenth at base of left lung.

In *right iliac fossa* there was slight tenderness, and slight sense of resistance over an area about the size of half-a-crown; resonance not impaired here.

Respiratory system.—At lower part of left chest there was deficient entry of air. Left chest moved better than right at upper part.

Heart sounds.—Second reduplicated at apex.

Progress and treatment.—June 1st. Rigor at 11.45 p.m.; temperature 107; pulse 112; respiration 32. A second rigor at 10.30 a.m.; temperature 99; pulse 80; respiration 23. Enema Suppos.; Gargarisma Pot. Chlor. Nutrient Enemata 4tis horis. (milk, egg and brandy). Nutrient Suppos. 2dis horis. Enema Aq. Calidæ. Oj. s.o.s., I.M.H. gr. ¼, 6 p.m.

Operation.—A.C.E. having been administered, Mr. Dunn made an abdominal section in middle line, three inches in length, about one and a half inches from xiphoid appendix. In examination, Mr. Dunn got his hand above and behind liver. No collection of fluid was felt either above or below it; there was some flaky lymph between it and stomach; no adhesions; gall bladder normal and full of bile. In closing up the wound, some fæcal-smelling thick pus was observed oozing up between liver and stomach. A drainage-tube was inserted after irrigation with warm water, and wound stitched up and dressings put on. After operation patient had another rigor. Temperature 104·4; pulse 108; respiration 32.

Before operation erythematous rash, which Dr. Hale White thought was septic, was extensive over forehead, trunk, arms and legs. Patient sweated profusely.

2nd. About ʒj. fæcal-smelling pus was drawn off through tube, and fresh dressings were put on. Patient seemed easier and more comfortable. Septic rash had almost cleared up. *Urine*—dark; no bile pigments; no albumin; no sugar; sp. gr. 1024, acid; I.M.H. gr. ¼, 1.30 a.m. at 6 p.m.; brandy ʒss. 2dis horis; warm water; Griffiths' Nutrient Suppos. j. 2dis horis; milk ʒj.; egg ½; brandy ʒss. 2dis horis., 10 p.m. Temperature 103·2; pulse 120; respiration 36.

3rd. Patient comfortable; wound dressed, more pus, about ʒi. was drawn off. Temperature 102·4; pulse 100; respiration 30 at 10 a.m. I.M.H. gr. ¼, 6 p.m.

4th. I.M.H. gr. ¼, 5 a.m. Condition of patient, bad. Temperature 102·8; pulse 128; respiration 32. Septic rash appeared again on arms. Wound dressed, and more very foul pus drawn off. Pulse became very small, and thready; he was very sick, bringing up a considerable quantity of coffee-grounds vomit, and death took place at 7.45 p.m. Inj. Strychnine Hyp. 1 per cent. ♏iij. at 12 noon. Inj. Brandy ♏xx. Inj. Strychnine ♏v., 2.30 p.m. Inj. Ether Hyp. ♏xx., 5.30 p.m. Brandy and milk, a little, 6 p.m.

Autopsy.—The vermiform appendix, which was five inches long, was found to be taking a vertically upward direction over third part of duodenum and terminating at the lower border of the pancreas. At extreme apex there was a perforation in communication with abscess behind pancreas and pyloric end of stomach, and lying on superior mesenteric vein with which it had free communication. The drainage-tube, inserted at operation, was found to have rested in the immediate neighbourhood of this abscess, from which pus had oozed up between liver and stomach. The mesenteric vein was plugged by septic clot, and pus was found in portal vein; and there were numerous pyæmic abscesses in liver. Behind cæcum there was a perforation which had set up a local abscess, and a second more recent perforation in front. There was acute peritonitis, and about ʒxx. of yellow opaque serous fluid, becoming purulent, was found in abdominal cavity.

Diagnosis.—From the condition of patient and owing to number of rigors associated with the abdominal pain and tenderness, Dr. Hale White thought the case one of localised intraperitoneal abscess. From the sudden onset it was pointed out that probably the abscess was due to perforation of a viscus, possibly from gastric or

duodenal ulcer, especially as the pain, tenderness, and fulness was locally situated in the neighbourhood of the liver and stomach. The discharge of pus after operation from deep down between the two viscera, made this diagnosis more probable. In view of the occasional pain in right iliac fossa, and the tenderness there on admission, the possibility of perityphlitis, and the retroperitoneal burrowing up of an abscess tract from this source at back of abdomen, was discussed. It was thought that the rapidity and course of the disease were against this. The autopsy showed this latter view to be incorrect, and demonstrated the presence of an abscess in connection with a hollow viscus. It is excessively rare for a localized abscess, in connection with the appendix, to be found in the position of that in this case.

MARY.

9. Cerebral tumour. J. B., æt. 14. Five weeks ago patient had headache and vomiting. The headache was localised to the left temporal region, was moderately severe, but did not keep the patient awake; the vomiting was unaccompanied by nausea, and was an immediate regurgitation of anything she ate; the vomiting lasted some days, diminishing in frequency, and then ceased.

Four weeks ago she had a fit; the right wrist became paralysed first, and then the whole arm, she was unable to speak, this lasted about ten minutes; she does not think there were any convulsive movements.

Three weeks ago she had internal strabismus (R.E.), and was admitted into Ruth ward. The strabismus disappeared in a few days; while she was in she had several attacks of vomiting; optic neuritis was present.

On admission into Mary ward she had no headache, and had not vomited. There is well marked optic neuritis, the edge of the disc is almost indistinguishable, and the disc is considerably swollen; the vessels are considerably obscured just beyond the disc, and they are tortuous; when she was under Dr. Brailey, numerous hæmorrhages were noted. Beyond being somewhat anæmic, she presents no signs of disease besides optic neuritis. The pulse is rather rapid, 100.

SOME REMARKS MADE BY DR. HALE WHITE.

From the history it was pretty obviously a case of *Cerebral Tumour*.

Headache is very common, and often caused by slight ailments, but whenever a patient is kept awake by it a suspicion of some more serious disease should be aroused, for often the headache in cerebral tumour keeps the patient awake.

The *vomiting* in this case was typically cerebral, *i.e.* it was unaccompanied by nausea, and consisted of a prompt regurgitation of food.

Optic Neuritis is very important, and if it exists alone without any other symptoms, the probability is that it is caused by cerebral tumour; *very* rarely cases of primary optic neuritis have been observed.

Fits.—In most cases of cerebral tumour they are very important as a guide to the localisation of the tumour. In this case, although no convulsions are known to have occurred, yet the affection of the right arm, and the arm only, and the fact that during the presence of the paralysis she was aphasic, pointed to the presence of a tumour in the lower part of the arm area. The effects of cerebral tumour are very much like those of electrical stimulation of the cortex, viz., they tend to diffuse; thus, although the probability is that the tumour is pressing on the wrist area (for she says that movement of this was especially impaired), yet as the whole arm and speech were affected, the effects due to the presence of the tumour spread both upwards to the area from the arm, and downwards to Broca's convolution. When, as in this case, paralysis predominates over convulsion, the tumour is probably rather immediately subcortical than on the surface.

As to the nature of the tumour.—Tubercle and glioma are by far the most common; and as there are no signs of tubercle elsewhere in the body, and there is no family history of tubercle, it is probably a glioma. (Dr. Hale White referred us to a lecture on Cerebral Tumour, reported in the GAZETTE for February 24th, 1894.)

Notes from Out-patients.

MR. JACOBSON'S.

A man, æt. 60, complaining of dry tongue. This presented in centre of posterior and middle thirds an oval patch, dark black in the centre, brownish at the margins. To the eye and finger the patch was softly shaggy, with very delicate plush-like processes. The history given was one of two years; the patches were white first, then brown, gradually becoming darker. Patient stated that he has not smoked for two years, up to that time his average quantity was one ounce of "Returns" a week. At one time he had "a bad throat" for seven or eight years. There is a leucomatous patch at the right commissure of the lips, resembling a streak of white paint.

Diagnosis.—Black tongue, *i.e.*, a peculiar form of chronic glossitis. The term Icthyosis given by some of those present was objected to, as the condition here was one of late life, whereas icthyosis of the skin was a congenital affection. Microscopically the fringes would show greatly hypertrophied epithelium. It was doubtful whether the colour was due to pigment granules, or to a peculiar black micro-organism. Micro-organisms, as was well known, formed a large amount of what we called "fur" on a tongue. In this case Mr. Jacobson looked upon the change as degenerative in nature. In favour of this view was the history that the disease began in a white patch, probably leucomatous; the existence at the present time of a similar labial leucoma, and the history of a long-standing sore-throat. Black tongue was usually met with in people past middle life, and, often, in those pulled down in health. If met with in early life it should always raise the suspicion of malingering. Such black stains, but without the plush-like papillæ, might date to the use of ink, steel, cherries, etc.

As to *treatment*, in this case the chief thing was to watch the condition as a possibly "precancerous" one. Constitutional remedies for the syphilis would be useless, though with regard to this point it was interesting to note that Mr. Hutchinson, who had described syphilis as a cause of overgrowth as well of destruction of tissue on the tongue, as elsewhere, had pointed out that secondary syphilis might produce warty growths in the same part of the tongue as we here had black tongue in a patient probably syphilitic.

The chief points to lay stress on, as in other possibly "precancerous" conditions, were the avoidance of all irritants, *e.g.*, pepper, salt, pickles, cheese, effervescing drinks, tart or sour things, and hot or very cold foods. The patient was directed to use a solution of Chromic Acid, 8 gr. to ʒi. But it was pointed out that solutions of Sod. Bicarb., or the application of Sodæ. Salicyl. would probably be more efficient. If these failed, and the patch gave further trouble, Acid Mercury Nitrate, or the actual cautery might be carefully applied, it being always remembered that either of these only substituted one structure liable to degenerate for another.

Case for Commentary.

A SINGLE woman, aged forty-eight, hitherto bright and active, taking the prominent part in a large business, received a great mental shock three years ago, on the death of her brother, and she fainted once at that time. Ever since then she has been losing mental energy. Writing a letter or adding up accounts have become much more trouble than formerly, and in the last six months her sister states she has become so apathetic that she would lie in bed all day if allowed; will take a whole morning to dress, and will often not know the day of the week. Her hands and feet are always cold, and she will sit crouching over the fire for hours together silent, and apparently lost. On Easter Monday, she first had what she calls "an attack," which commenced suddenly, with intense frontal headache, and a sulphurous taste in the mouth. She went ashy pale, and felt a sudden loss of strength, but she never lost consciousness. She has had many such since.

On examination, she is quite herself, talks on any common-place subject, and answers any question addressed directly to her, not only correctly but intelligently, though very slowly, and she relapses at once into a dreamy condition. She is not in the least melancholic, being rather amused than otherwise at what she calls her "stupid complaint."

There is no paralysis of any kind, but when she walks she appears to be using an effort either to maintain her equilibrium or to make her muscles work.

The heart and lungs and abdominal organs are in good working order. The special senses are all natural, and the fundus oculi is healthy.

The case is submitted to you for your report as regards the nature of the case, its prospects, and its treatment.

Immunity.

A Paper read before the Physical Society, March 3rd, 1894, by Mr. E. A. PETERS.

(Concluded.)

Such are some of the facts we know concerning the particular methods of infection by microphytes. It is seen that they vary a good deal in distribution, method o attack, and virulence. The whole matter depends on the variations and physiological effects of two factors, (1) the microphyte; (2) the animal. It has been pointed out that the microphyte varies considerably, both naturally, as in cholera, and artificially as in diphtheria. In most cases, what is observed in inoculation, is leucocytosis and phagocytosis, with death of the microphytes, or rapid increase with fatal results to the animal, and tissues by toxins. Such a development of toxins is the most important to the pathogenic career of the microphytes. The method of *toxin* formation we do not know, except that it is, in virulent species, closely bound up with the growth inside, and frequently outside the body. From immunised animals experimenters have separated bodies, one of which causes, directly or indirectly, the death of the organism, while others seem to cause the destruction of the toxin and are called anti-toxins.

In attenuated virus, the poison is diminished in amount, or the change is one of degree. Attenuation effects either a somewhat permanent change, so that the attenuated organism breeds true, or the change is only temporary. Thus, from the microphyte side of variation, comes a cause of mild disease. In rabies, Pasteur thinks it necessary that the particulate as well as the soluble agents of the modified virus are necessary.

It may act by causing merely a modified attack—most vaccinations cause a reaction—and so causes some actual change in the functions of blood tissues, or of special cells; or, on the other hand, an anti-toxin or substance with definite bactericidal properties may result as a definite body, or enter into permanent chemical relation with tissue or fluid, and so cause the change.

This will be considered later. Suffice it to say that the duration of this property is very variable, but bears in some cases, a distinct ratio to the amount of virus used. With changes from the animal side of the factor, apart from predisposing causes, diminished health, lesions, etc., which may be compared to some attenuations of bacteria, we come to the kernel of the whole matter—immunity. Immunity is a relative term for the outcome and sum of all these inter-acting factors.

It may be divided into natural and acquired.

1. Natural immunity.

(*a*) The nearest approach to absolute immunity is seen in normal cold-blooded animals, with regard to the bacteria of warm-blooded animals. Even this natural immunity is diminished by changed circumstances, *i.e.* chloroform narcosis, and elevated temperatures.

(*b*) Warm-blooded animals are immune against ordinary saprophytes.

(*c*) Plants are immune against bacteria.

Again, certain warm-blooded animals are insusceptible under ordinary conditions, but under certain changes are susceptible.

The adult meat-fed rat is immune to anthrax, but fed on bread submits to infection. This may be an acquired property by natural selection, for young rats are susceptible. Rats are essentially scavengers, so we should expect them to come into considerable contact with bodies dead of anthrax. Besides, their funereal habits of eating their own dead would cause a very wide distribution of the disease. Anthrax occasionally does occur among rats, but were the rats susceptible, a very great destruction would take place among them. In the rats mentioned above, Hankin finds that the defensible proteids are present in corresponding amounts, being minute in the susceptible rat, sometimes only a trace, while marked quantities are present in the spleen of insusceptible animals.

The Algerian sheep may be mentioned as one of the most immune animals.

Then comes the relative immunity of tissues. The muscular tissue is considered to be relatively immune in mammals. The skin is also usually unaffected except in exanthemata. All tissues, relatively to the blood, are immune according to Buchner, in cholera, typhoid, typhus, and tubercle.

2. Acquired immunity results from (1) A previous attack of the disease, *i.e.* the exanthemata. (2) Preventative inoculation of weakened cultures (rabies). (3) Inoculation of non-virulented cultures. (4) Active bodies which bring about bactericidal results or destroy toxins (diphtheria and tetanus).

Immunity again is either absolute, of which there are the rare examples mentioned above, or partial. This is said to exist when the disease is interfered with, localised, or the course of the disease is modified.

In recovery from disease, there is usually immunity from a further attack, with rare exception. But in some —erysipelas, gonorrhœa and pneumonia—this is of a very passing nature. However, there are very few diseases to which man is subject to which he is not relatively immune, and even in those which do cause septicæmia a localised form is not uncommon. Complete susceptibility means septicæmia from a particular organism and complete immunity to affect, on that organism.

Between these there come several classes in which the disease is localised though it may be fatal by toxins.

Healing processes and inoculation throw most light upon the subject. The constituents of bacteria are, according to Buchner:—

1. Amido acids.

2. Proteins which, when the bacteria die, enter into solution.

There results from the interaction of bacteria with albumin (according to Sidney Martin) in some cases albumoses with which is a poison of ferment-like action. Alkaloids and acids may also result. In some cases only do bacteria have this enzymic function.

Injection of organisms and their products, or the products alone, cause a varying amount of disease, culminating possibly in death, or a varying amount of immunity.

In most cases, except in completely susceptible cases, and occasionally in some of these, leucocytosis and phagocytosis results. In the partially immune this phenomena occurs also; but even in these cases sometimes bacilli may be all killed without the concomitance of phagocytosis. Phagocytosis in the original sense meaning mechanical destruction of all bacteria of disease by cells alone, which, like our Volunteer forces, wrestle with the invader—such phagocytosis is a thing of the past. Undoubtedly they do destroy the bacteria as well as remove the dead microphytes. Metschnikoff, in 1883, set forth his unmodified theory of phagocytosis; later, however, he has admitted the assistance of tissue fluids in the phenomena.

He noticed in Daphnia a water-flea, that when certain fungus spores attempted to enter the body tissues from the alimentary canal, they were attacked by the colourless cells and apparently digested. If all the fungus spores were not exterminated in this way then they increased in number, and the Daphnia died. Again, this is very frequent in the case of inoculation of animals, with a pathogenic organism. Local œdema apppears and an increase of leucocytes takes place. In the veins there are often one white to thirty-nine red corpuscles. This increase is due to division of leucocytes by amitosis principally; besides these corpuscles there are cells of mesodermal origin, which alone act as phagocytes, according to Roux. They are microphages, large cells with a homogeneous looking nucleus, and microphages which some consider to be leucocytes, but differ from the ordinary leucocytes in having a larger body substance, and frequently many nuclei.

These two kinds of cells in a relatively immune animal, take into their body substance the bacilli and destroy them. They are not dead, for often bacilli are noticed coming out of dying phagocytes. In the anterior chamber of the eye which is free from leucocytes, pathogenic bacteria grow luxuriantly. According to these ideas a healing process is explained by the destruction of the virus; and septicæmia by the non-resistance of the phagocytes, which is said to be due to paralysis of the cells by the toxin evolved. Immunity, then, results by the adaptation of the leucocyte to the particular poison. It has been suggested that if this last were true, all disease would be stamped out by now. The objection is probably untrue, for the principal requirement for a factor to be efficient in natural selection is continuous action, which does not exist in the case of the more acute diseases. That the effect of specific poison has varied considerably, is to be seen in the probable disappearance of such disease as the sweating disease, which possibly is now localised to parts of France, though previously it was known as

the English sweat. Again, the terrible ravages of measles introduced among a virgin population in the Southern Sea seems to be a case in point.

Bordet found that a substance is formed by the virus which attracts the leucocytes. Fine tubes containing various substances were placed in the abdominal cavity, and were found to have a negative or positive effect in attracting leucocytes (chemiotaxis). Thus, lactic acid has a negative effect, while other substances attract the leucocytes. One of these is the protein from bacilli. Injection of this causes a rise of temperature and leucocytosis. This has lately been confirmed by Roemer, who shows that this is marked especially in the veins where there may be leucocytes in thirty-nine corpuscles. The attraction of bacteria to special tissues, in exanthems to the skin, may also be noted.

Then comes the striking fact that blood serum is fatal to bacteria (Nuttall), though if the bacteria exceed a certain number growth takes place after a check. Also the serum of naturally and artificially immune animals kill the virulent bacteria effectually, according to the degree of immunisation. And there is proof that bacilli are killed in the blood without phagocytosis.

If packets of anthrax, arranged so that the leucocytes cannot reach the bacilli, are introduced into the ab-i dominal cavity, by the tissue fluids, of a frog, the bacill are shortly killed (Buchner).

Anthrax spores lose their virulence if thus placed in a packet after eleven days (Pekelhering).

Again, in cases of susceptible as well as immune animals there is no phagocytosis occasionally.

Bouchard has shown that the serum of rabbits does not destroy pyocyaneus cultures, while the serum of the immune animal will not permit of growth.

Buchner, examining the property of tissue fluids, find that:—

1. Peptones do not kill cholera, typhoid or anthrax microphytes.

2. Warmth destroys the bactericidal power (55° C. for 1 hour).

3. Dilution with normal saline solution does not interfere with the action.

4. That some serums are not so effective as others.

5. The blood has the same property.

There is also evidence that frequently one substance is fatal to the bacillus, and another neutralises the toxin. Thus no animal is tolerant of diphtheritic poison. The serum of the rat is fatal to the bacilli but does not touch the toxin. Kitasato found that injected serum from an immune rabbit destroys the diphtheritic poison with the bacillus. Gamaleia's experiments with Vibrio Metschinkoff's show similar results.

Hankin separated proteid cell globulin B from the spleen of naturally and artificially immune animals, and found it to be present in the spleen in quantities proportionate to the immunity of the animal as detailed above in the case of rats.

Ogata has separated a body soluble in glycerine with bactericidal powers.

Tizzoni and Cattani's experiments also show the same result in the case of tetanus.

It is noticeable that a very large amount of these defensive proteids are derived from the spleen, which is very rich in cells of the phagocyte type. It is not improbable, therefore, that the defensive proteids are used by the phagocyte for the destruction of contained bacilli or that the defensive proteids result from some metabolic change connected with them.

Respiration is ultimately a matter of the property of hæmoglobin, but that is aided and placed under suitable conditions for respiratory function by the action of many constituents of the blood, and even its formation is a matter of mesodermal activity. The action of poison on cells is very variable whether animal or vegetable. Though the ultimate working of immunity is due to albumoses, globulins or other proteid body, or to some ferment acting with them, still the production of that body is effected by a mesodermal agency, though by which portion of the blood tissue we do not know.

Accordingly, it may be expected that the cries of "phagocyte" and "tissue fluids" will disappear, and among the properties of the mesodermal blood will be placed a variable property, depending on many factors, immunity.

Calendar of Coming Events.

June 9th.—1st XI. v. Dunstable Grammar School, at Dunstable.
2nd XI. v. Whitgift Wanderers, at Honor Oak Park.

„ 11th.—Last day for applying to Registrar for form of entry for Preliminary Scientific London.

„ 12th.—Prize Competition for Fourth Year's Students.
Guy's Hospital Rifle Association. Prize Competition, Ilford.

„ 13th.—1st XI. v. Mote C. C., at Maidstone.
2nd XI. v. Dulwich College, at Dulwich.

„ 14th.—Guy's Hospital Christian Union. Three short Addresses by members. G. F. Still, M.A., M.B., B.C., in the chair.
Schedules for Third Conjoint Examination to be left at the Medical Office, not later than this date.

„ 16th.—1st XI. v. Streatham, at Honor Oak Park.

„ 18th.—Guy's Hospital Rifle Association v. Whitgift, at Marden Park.

„ 20th.—2nd XI. v. Bromley, at Bromley.

„ 21st.—Guy's Hospital Christian Union. Address: "Is God in Everything," by J. W. Jordan Esq.

„ 23rd.—1st XI. v. Mitcham, at Mitcham.
2nd XI. v. H. Hewetson's XI., at Honor Oak Park.

Passim.

Through the courtesy of the Author, we are allowed the privilege to announce the completion and publication of Dr. Pavy's new work, "The Physiology of the Carbohydrates, their application as food and relation to Diabetes." We may be pardoned any feelings of pride at the great distinction which Dr. Pavy has conferred on the Gazette by presenting us with the very first bound volume of his life's work, on a subject of such far reaching significance to the medical profession. In the preface, Dr. Pavy says: "A life's labour, attended with increasing laboratory work, has been devoted to the attainment of the knowledge that has been acquired"; and pays a graceful tribute to his old school in these words, "To the authorities of Guy's Hospital I shall ever feel grateful for the assistance rendered in the cause of science by the provision of laboratory accommodation throughout the period of my association as a member of the acting Staff." We are also pleased to draw attention to the announcement in another column of the Croonian Lectures, to be delivered by Dr. Pavy, a few tickets for which have been, through his kindness, left at the Medical Office for any of those who wish to be present. They may be had on application at the office, and will doubtless be very quickly disposed of.

We are requested to announce that Sir George Humphry, M.D., F.R.C.S., LL.D., F.R.S., will distribute the Prizes on July 4th, and not on the 18th, as stated in our last issue. The alteration has been made to enable Old Guy's men and others to attend the Biennial Dinner, which is to be held the *same* evening. It was found that the two Senior Surgeons would be examining on July 18th, hence these changes.

We notice that applications are invited for the following appointments, which commence on October 1st:—Two Assistant Demonstrators of Anatomy; one Assistant Demonstrator of Physiology; and eight Prosectors. The 13th June is the last day for sending in applications to the Medical Office for any of these appointments.

In accordance with the notice which appears on another page, we are able to state that changes rendered necessary by the retirement of Mr. Durham are now made complete. Mr. Golding-Bird has been appointed on the Senior Surgeons' Staff, Mr. Dunn taking his place on he Junior Surgeons' Staff. For other appointments on the Junior Staff our readers are referred to another column.

The results of the elections to the Council of the Clubs' Union, which have been taking place during the last month, are now made known, and the names of the new Members will be found in the report of the Council printed in another part of our issue. The method of election of Student Members, though somewhat complex, seems to work well, and the present Council is certainly a very strong one. We note that Mr. Bell is the only Student Member who has previously served on the Council, while of the Staff Members, the only change has been the election of Dr. Pye-Smith, to fill the vacancy created by the retirement of Mr. Durham.

We are sure that every member of the Union will cordially sympathise with the regret expressed in the report of the Council, that Mr. Durham's period of office, as President of the Union, now comes to a close. We could almost wish that the laws of the Union did not prescribe that no President should hold office for more than two years in succession. In Dr. Pye-Smith,

as the new President, however, we have one who has already shown his interest in the Union in a very practical manner, and under whose Presidency the progress of the Union is assured. We have also to convey our best thanks to Mr. Brailey and Dr. Shaw, to whose efforts, as Treasurer and Secretary respectively, the success of the amalgamation scheme is in a great measure due.

As already announced in Passim, some changes have taken place in the *personnel* of the management of the Students' Club. Mr. Durham, everyone will rejoice to hear, has kindly consented to again fulfil the office of President. Mr. Fripp, who has so ably carried out the arduous duties of Secretary in past years, has been obliged to resign, but the interests of the Club will, we feel sure, be well served by Dr. Fawcett, who succeeds him, especially as Mr. Symonds retains the Treasurership. Mr. H. J. Spon has been elected Assistant Honorary Secretary, *vice* Mr. R. H. Fagge, the various Sub-Committees being constituted as follows:—Newspaper: Dr. Washbourn and Messrs. A. V. Clarke and C. H. Bryant. Catering: Messrs. A. V. Clarke, H. T. Bell, and Secretary *ex officio*. Clubs' Union Representatives: Messrs. B. G. Reynolds and H. T. Bell. Gymnasium Representatives: Messrs. H. J. Spon and B. G. Reynolds.

THE decoration of the Reading Room window sills with flower-boxes and flowers has, we understand, been the work of the new Students' Club Committee, and it only remains for *all* the College residents to do the same by their ledges to make the whole quadrangle a pleasant sight to the eye, and the admiration of all.

WE have to acknowledge No. 1 of the *London Hospital Gazette*, which appeared on Wednesday. It is covered in a somewhat elaborately designed blue wrapper, and is a production of distinct merit. We are informed in the editorial column that it is the "paper of the Clubs' Union," and "written for students by students." This is as it should be, and we are reminded that the *London Hospital Gazette* makes the fifth journal produced by the students of the medical schools in the metropolis. Contributions are invited on subjects of scientific as well as of general interest. The number under notice contains much of the latter, but in the future, doubtless, the journal will grow, and the insertion of cases of interest, clinical lectures and teaching will follow as a matter of course. Among the excellent articles appearing in the May number there are a smartly written "Study of Student Life—The Chronic," an interesting account of the "Barber-Surgeons," and an account of the doings of the various institutions and clubs at the end—an arrangement, curiously enough, we have adopted for the first time in the current issue of the GUY'S GAZETTE. We re-echo the hope of the editorial staff of our new contemporary in wishing "their latest effort in journalism a brilliant and continuous success."

A MONTH ago we published, under the heading "Pathological Poesy," an "Ode to the Heart," by the new Poet. If it be true "that troubles never come singly," it is equally true that there is no end to the effusions of poetic enthusiasts, and our enthusiastic contributor is not the exception to the rule. We have this week received "The Operator; or, The Hospital Smithy," very much after Longfellow, which space prevents us from inserting in our own columns. We would humbly advise our Poet to impart the knowledge, which in his own words—

> "Thus in the operating theatre
> I have found, what I have sought,"

to others through the medium of such a *fin de siècle* journal as "The Y——w B—k." Our

readers have hardly reached the state necessary to appreciate his praiseworthy efforts with the savour they deserve.

WE have sometimes heard complaints of the lack of interest exhibited by Guy's men in some of the Inter-Hospital contests in which we are taking part. It may be some consolation to know that we are not worse than others. On the best authority, we hear that at a recent Inter-Hospital cricket match, *one* spectator passed the turnstiles. It is not known whether he was a supporter of the victors or the vanquished.

AMONGST those presented to the Prince of Wales, at the Levée held on the 4th inst., was Dr. H. J. Roberts, an old Guy's man. The presentation was made by the Marquis of Anglesey, Hon. Colonel of the 2nd Volunteer Battalion Royal Welsh Fusiliers. In this corps Dr. Roberts formerly held medical rank, but, having by his sole effort, raised a company of over a hundred men, he now very fitly commands it as Captain.

ALL Guy's men will have seen with pleasure the name of W. J. Scott among the Middlesex County team, *v.* Gloucestershire. We heartily congratulate him on obtaining at last the place that we thought him entitled to years ago. Without doubt, he has done more for Guy's cricket than any other man, which is a great deal to say and something to be proud of. This information may be useful to the omnipotent gentleman who writes cricket notes, full of personal pronouns, for the *Morning Leader*, "whoever he may be."

DR. REGINALD KOETTLITZ, upon leaving Butterknowle, where he had been in practice for nine years, was on May 17th presented with a valuable surgical instrument and a purse of sovereigns, as a token of esteem and respect, by the inhabitants of Butterknowle and neighbourhood.

Pass List.

Royal College of Surgeons England, May, 1894.

FINAL FELLOWSHIP EXAMINATION.

Beddoe, D. M.	Lister, T. D.
Durham, H. E.	Ouston, T. G.
Leathes, J. B.	Sichel, G. T. S.

University of London, May, 1894.

M.B. PASS EXAMINATION.—SECOND DIVISION.

Adams, E. L.	Kemp, G. L.
Allan, A. P.	Miller, A.
Huntley, E.	Parry, L. A.

Royal College of Physicians of London.

DR. PAVY will deliver the Croonian Lectures, on "A New Departure in Connection with Diabetes," at the Examination Hall, The Savoy, W.C., on the following Tuesdays and Thursdays at five o'clock—June 19th, 21st, 26th, 28th. By order of President,

WILLIAM FLEMING, *Bedell.*

Appointments.

COULSON, J. E., M.R.C.S., L.R.C.P. Lond., has been appointed Junior Assistant Medical Officer at St. George's Infirmary, Fulham Road.

DEANE, EDWARD, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Caversham Sanitary District of the Henley Union, *vice* Cockran, resigned.

HOPSON, MONTAGU F., L.D.S. Eng., has been appointed Dental Surgeon to the Hampstead Hospital.

HARRIS, J. W., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Frittenden Sanitary District of the Cranbrook Union, *vice* Wood, resigned.

PANE, J. W., M.D. Edin., C.M., L.D.S., has been appointed Demonstrator to the National Dental Hospital.

RAKE, A. T., M.B. Lond., M.R.C.S., has been appointed Registrar and Pathologist to the East London Hospital for Children, Shadwell, E.

ROBERTS, EDWARD, M.R.C.S., has been appointed Surgeon to the Manchester Eye Hospital.

Acknowledgments.

The Physiology of the Carbohydrates. Their Application as Food and Relation to Diabetes, by F. W. Pavy, M.D., LL.D., F.R.S. (London, I. & A. Churchill).

The Cambridge Review.

The Hospital.

The Medical Pioneer.

The London Hospital Gazette.

University of Cambridge.

PATHOLOGY AND BACTERIOLOGY COURSES. LONG VACATION, 1894.

Professor Roy's Notice.

The Professor of Pathology gives notice that the following courses will be held in the Pathological Laboratory during the long vacation:—

I. Course in Bacteriology.—This will be given by Dr. A. A. Kanthack, with the help of Mr. L. Cobbett, Mr. J. H. Drysdale, and Dr. J. Lorrain Smith, and will consist of lectures at 2 p.m. on Mondays, Thursdays and Fridays, each lecture being followed by practical laboratory work and demonstrations lasting till 6 p.m.; but those attending the course will be allowed to continue their laboratory work at other times.

The following short summary will serve to show the scope of the work:—

1. The preparation of culture media.
2. Morphology of microbes.
3. Artificial cultivation of ærobic microbes.
4. Artificial cultivation of anærobic microbes.
5. Staining of microbes in fluids and tissues.
6. Modes of inoculation and special characters of pathogenic microbes.
7. Examination of principal pathogenic microbes.
8. The nature of immunity from infective diseases and the modes of producing it.
9. Serum-therapeutics.
10. Isolation of bacterial products, their chemistry and physiological actions.
11. Diseases of animals communicable to man.
12. Antiseptics and disinfectants.

The course will commence on July 9th, 1894.

As the number of places is limited, those proposing to attend should send in their names to L. Cobbett, Esq., M.B., New Museums, Cambridge, as soon as possible.

Fee for the course, including apparatus, chemicals, etc., and use of immersion lens, £6 6s., payable to A. E. Shipley, Esq., M.A., New Museums.

II. Elementary Pathology Course.—The Long Vacation Course in Elementary Pathology will commence on July 10th, at 12.

The lectures will be given by Professor Roy, thrice weekly, on Mondays, Wednesdays and Fridays.

The practical part of the course will be held thrice weekly on Tuesdays and Wednesdays from 2 to 4 p.m., and Saturdays from 9 to 10 a.m., by the Professor and Dr. Lazarus-Barlow.

Fee £3 3s., payable to A. E. Shipley, Esq., M.A., New Museums.

Pathological Laboratory,
New Museums, Cambridge,
May 18th, 1894.

From the Gazette's Special Pathologist.

All specimens, especially tissues and growths, should be accompanied by a short history.

M. D., Canonbury.—Many thanks for report. The M. D., Highbury, specimen showed large oval cells in a blood-stained mucoid sputum. Kindly send another specimen, since these cells were not obtained in the last.

W. H. R., Kingston.—No tubercle bacilli were found in the specimen sent. There were numerous pus cells, but no epithelium of diagnostic importance.

S. C. W., Ashford.—No tubercle bacilli present.

H. W. W., Rickmansworth.—Tubercle bacilli present.

C. G. R., Halstead.—Tubercle bacilli present.

E. M. D., Swansea.—Tubercle bacilli present.

T. H., Garstang.—Many thanks for history of the case. A primary growth from the region of the cricoid wall seems the more probable solution. The evidence from the circumstances, however, is not conclusive.

J. R. A., Sherborne.—The specimens from horse show probably a leuchæmic condition of the liver, together with a nodule of sarcomatous tissue. The testicle is involved with a similar sarcomatous growth.

F. H. K., Huddersfield.—Kindly send a few details of the case.

E. L. A., Tunbridge Wells.—Tubercle bacilli present.

J. T. F., Huddersfield.—Interlobular atrophic cirrhosis of liver. There is a large amount of fatty change, and slight apparent increase of bile ducts.

A. R., Eastbourne.—No tubercle bacilli were found.

D'A., Buckingham.—No malignant cells were recognised in the casts, which consisted of fibrinous blood-clot with particles of caseous material.

H. G. A., Nottingham.—The specimen from cervix shows many hæmorrhages and some active growth. There is no evidence of malignancy in this portion.

H. W. M., Kidderminster.—A rapidly growing small celled sarcoma.

G. H. J., Teignmouth.—The specimen shows the structure of a rapidly growing melanotic sarcoma. Many thanks. The growth has been placed in the museum.

W. Salisbury.—(1) The growth is a rapidly extending epithelioma. (2) The cervix is much hypertrophied by an increase of connective tissue, which is evidently chronic. There is no infiltration, but there are several hæmorrhages in the superficial parts.

H. R. M., Hastings.—A few tubercle bacilli are present.

PATHOLOGIST.

Specimens for examination and description in this column should be addressed to H. Hunt, Gazette, the Museum, Guy's Hospital, S.E., and should be accompanied by a remittance of 2s. 6d.

Voces Populi.

SCENE.—*The Front Surgery—A busy morning—Medical bench, gangway, and exits packed with impetiginous infants and perspiring matrons. Enter H. P. for week, careworn but resigned.*

H. P. (*loquitur*). "Now then, who was here first?"

ALL. "Why, to tell yer the truth, doctor, and I wouldn't tell yer a lie, doctor, I believe I and my little gal was."

H. P. (*taking up a position on the outskirts of the crowd*). "Well, missus, what's wrong with your baby?"

Accosted Matron. "Well, doctor, it's werry strange, but that's just what I brought 'im up 'ere to ask you, what *you* thought was wrong with 'im."

H. P. "What did you notice wrong with him?"

A. M. "Well, doctor, I'm only a poor woman, and it isn't for me to talk to the likes of you, doctor, but my young man 'e says to me, 'Liza, what do you want for——?"

H. P. "Quite so, missus, but what made you frightened about him?"

A. M. "Well, doctor, to tell yer the truth, I'm sure I couldn't tell yer; yer see, doctor, it's just a kind of like this; I says to Mrs. 'Arris, I says (Mrs. 'Arris is a neighbour of mine, doctor), and I says to 'er——."

H. P. "Yes, I quite understand, but now, tell me this, does he suffer from sickness at all?"

A. M. (*coming to the point*). "Why, of course 'e do, doctor, throw up 'is food 'orrible-like, but not more, I reckon, doctor, than 'e ought to do."

H. P. (*thinking to himself, probably not, considering the diet he is subjected to*). "How are his bowels, missus?"

A. M. "Werry regular, doctor, in fact, as *I* think, a bit too regular, for everything he takes passes right through 'im, indeed it do, doctor, and what passes from 'im, it's just like blood and corruption, doctor."

H. P. (*slightly appalled*). "Has he got a cough, missus?"

A. M. (*indignantly*). "Corf, doctor, why 'e's 'ad a corf ever since 'e's been born, fit to corf 'is dear little eyes out, indeed, doctor, the phlegm 's always a risin' in his throat fit to choke 'im, and 'e do 'ack day and night something shockin' and if you *could* be so kind, doctor, as to take 'im in" (*affectionately caressing travel-stained infant*).

H. P. "We won't part you from him, missus, seeing you might feel the want of him so much, so don't you fret yourself. Just get his things off as quick as you can, so that I can examine him all over."

(*Interval of ten minutes*).

H. P. (*returning to his inquiries, and annoyed to find baby still submerged in swaddling-clothes, at least four lamellæ thick.*) "*Do* get his things off, missus, and hurry up about it."

A. M. (*indignantly*). "Yer needn't speak to me like that, doctor; 'ow was I to know yer wanted 'im stripped naked-like?"

[*Infant buries its head in maternal axilla, yells loudly, kicks out in all directions, and micturates forcibly. A disturbance is heard in the next room, owing to a gentleman on the verge of D.T. with retention of urine, declining surgical assistance, "No, I ain't a come up 'ere to be cut." Ambulance arrives with professional epileptic on it. Large crowd of policemen and others most anxious to restrain the fits from "working 'im too strong." A nurse darts in and out of the crowd, hither and thither, slightly increasing the existing confusion. Altogether the examination is conducted under difficulties.*]

A. M. (*with forlorn hope of getting him admitted*). "'Is little navel 's blown out something terrible, doctor, in fact I call it dangerous to leave a child like that, I do."

H. P. "Will he take a little cod-liver oil?"

A. M. "Well, I gives 'im 'is ile, regular-like, doctor, but 'e 'eaves aginst it." (*Directions as to feeding are cut short by the arrival of an infant that has taken some paraffin*).

(*An interval of ten minutes, during which paraffin-laden baby is washed out and admitted to Clinical*).

H. P. (*returning to his queue of patients. Preliminary parleying as before*). "What made you think there was anything wrong with him?"

Anxious Mother (*dandling marasmic seven-months' fœtus*). "Why 'e's a wasted away to nothink, like, doctor, and 'e was such a beautiful baby born, and 'e 'as got such a shockin' cold in 'is dear little nose, and 'e 's all for drink, doctor, and in 'is eyes, to tell you the truth, doctor, *I* believe it's the yaller jaundice."

H. P. "Has he had any spots about him?"

A. M. (*indignantly*). "Niver a spot nor a blimish, doctor, 'ow could you ask me sich a question?"

H. P. (*Undressing infant and exposing a copious eruption covering about three-quarters of the entire body-surface*). "What do you call this, missus?"

A. M. "Why the midwife, she calls it the thrush, doctor, for it's a been right through 'im, though meself I call it the gumrash, for it's my tenth baby and they've every one of them 'ad it, so I give 'im a saffron powder for it."

[*H. P., in last stages of collapse, prescribes a grey powder and proceeds to investigate remaining cases, over which we will draw a veil.*]

Διόγ.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—I am sorry to see that the insertion of the College Conjoint and Hall Examination Questions is to be discontinued. Personally the questions are a source of great pleasure and use to me, and likely to be doubly useful to my son when he "treads the colonnade of Guy's."—Faithfully yours,

"OLD GUYITE."

Guy's Hospital Medical School.

JUNIOR STAFF APPOINTMENTS.

The following appointments have been recommended by the Staff, and approved by the Treasurer, to the various departments, the duties of which will commence on October 1st.

Medical Registrar.—J. H. Bryant, M.D.

Demonstrators of Anatomy. — J. H. Targett, M.S., A. D. Fripp, M.S., and E. T. E. Hamilton, F.R.C.S.

Demonstrators of Physiology.—E. H. Starling, M.D., and J. Fawcett, M.D.

Demonstrator of Biology.—J. H. Campbell, M.D.

Demonstrator of Chemistry & Physics.—J. Wade, B.Sc.

Guy's Hospital Clubs' Union.

ANNUAL REPORT.—SEASON 1893-94.

THE Council of the Clubs' Union have much pleasure in presenting a report of the progress of the Union, together with a statement of the receipts and expenditure, during the past year.

The total number of members on the 31st of March, 1894, was 1,233, of whom 875 are life members, 331 annual subscribers, and 27 patrons. These numbers show a most satisfactory increase since last year, when there were 698 life members, 220 annual subscribers, and 27 patrons. The great advance in active membership and the continued support received from the Governors and Consulting Staff is very gratifying to the Council.

The fact that of the new life members more than 140 are old Guy's men who have left the Hospital and are engaged in practice in all parts of the country is strong evidence of the wide sympathy accorded to the objects of the Union. Particularly would the Council tender their thanks to the many old Guy's men who have added to their subscriptions donations in aid of the preliminary expenses.

One alteration has been made in the rules during the past year, with the object of allowing members whose course of study at the Hospital is necessarily a short one to obtain the privileges of life membership by payment of a correspondingly lessened number of annual subscriptions.

The Council believe that the Clubs' Union ground has been much appreciated by members throughout the year. More than 2,500 cheap railway tickets to Honor Oak Park have been used by members, and the football matches that have taken place there during the winter have attracted a large number of spectators. It has been deemed advisable to limit the number of strangers by making a charge for admission to all but members of the Clubs' Union, and with this object in view the Council have lately erected turnstiles at one of the entrances to the field.

Upon the recommendation of the committee of the Association Football Club the Council have consulted with an expert upon the question of the drainage of the portion of the field set aside for this Club, and it is proposed to carry out some suggested improvements at the end of the present cricket season.

The addition to the Clubs' Union Blue Book of a list giving, opposite to the various towns and districts at home and abroad, the names of the members of the Union practising in them has been warmly approved by old Guy's men. It is hoped that the means thus afforded to members in all parts of the world of finding a fellow member, either for professional or social purposes, will be of practical service to many.

The Council are glad to report that the arrangement they have made with the editors of the REPORTS and with the GAZETTE Committee whereby their life members may receive these two periodicals through the Union by the payment of a single annual subscription at a reduced rate has worked well. The circulation of both these journals has considerably increased since the formation of the Union, and the Council understand that their financial position is thoroughly satisfactory.

All the original constituent institutions remain in the Union and applications from two other clubs to be admitted are now under consideration.

As will be seen from the balance sheet, the receipts during the twelve months ending March 31st, 1894, have amounted to £1,532 11s. 8d., and the expenditure has been £1,679 11s. 4d. A balance of £93 9s. 4d. has been carried forward, a smaller balance than that of last year.

The Council desire to acknowledge the ready assistance they have received from the secretaries and treasurers of the constituent institutions in presenting and explaining their accounts, and are glad to report, in the words of their finance committee, "that the balance sheets and budgets have been more satisfactorily rendered than they were in the previous year."

Thanks are also due to Dr. Washbourn and Mr. Leathes for their services as auditors to the Clubs' Union accounts, and to Messrs. Wakefield, Huntly, and Scott, the auditors of the accounts of the constituent institutions.

The Council cannot close their report without expressing the regret, which they feel sure is shared by every member of the Union, that Mr. Durham's period of office as President now terminates. The Council have received the greatest possible assistance from Mr. Durham during his presidency, and they believe that the success of the Union is in large measure due to his generous sympathy and support. In conclusion, the Council have to report that their successors have been duly elected, in accordance with the rules of the Union, and that the following are the names of the new council:—

President: Dr. Pye-Smith.
Treasurer: Dr. Taylor.
Secretary: Mr. Fripp.
Assistant Secretary: Mr. Every-Clayton.

Auditors of Clubs' Union Accounts: Mr. Dunn and Mr. Munro.

Auditors of Constituent Institutions' Accounts: Mr. Hewetson and Mr. Steward.

At the same meeting the Debating Society and the Rifle Club were admitted to the Union. Votes of thanks were recorded to Mr. Durham, Mr. Brailey and Dr. Shaw for their services as President, Treasurer and Secretary respectively.

BALANCE SHEET.

Statement of Receipts and Expenditure from April 1st 1893, to March 31st, 1894.

April 1, 1893. RECEIPTS.	£ s. d.	£ s. d.
To Balance at Bankers ...	236 16 6	
„ Petty Cash in hand ...	3 12 6	
		240 9 0
„ Subscriptions and Donations from April 1, 1893, to August 31, 1893	295 12 6	
„ Ditto from Sept. 1, 1893, to March 31, 1894	1012 4 0	
		1307 16 6
„ Grant from Medical School Fund for 1893		100 0 0
„ Grant from Dental School Fund for 1893		10 0 0
„ Rent from Tenants		50 0 0
„ Ditto Lockers		6 0 0
„ Blue Book Advertisements...		12 12 0
„ Gate Receipts		3 4 6
„ Sale of Railway Tickets ...		42 18 8
		£1,773 0 8

Apr. 1, 1893. EXPENDITURE.	£ s. d.	£ s. d.
By Grants to Constituent Institutions—		
„ Athletic Club	40 8 6	
„ Bicycle Club	5 5 0	
„ Cricket Club	31 6 6	
„ Football Club (Association)	10 0 0	
„ Do. do. (Rugby) ...	30 10 0	
„ Gazette Fund	239 5 0	
„ Physical Society	28 0 0	
„ Prayer Union	11 0 0	
„ Reports Fund	225 0 0	
„ Students' Club 274 19 3		
„ Do. Debt... 75 0 0		
	349 19 3	
„ Tennis Club	16 10 0	
		987 4 3
„ Field Current Expenses ...	187 2 4	
„ „ Preliminary Expenses	81 19 4	
„ „ Rent Account ...	242 10 0	
		511 11 8
„ Amount written off Capital Account		50 0 0
„ Management Expenses—		
„ Printing and Stationery ...	46 18 2	
„ Secretarial Expenses ...	37 9 0	
„ Petty Cash Disbursements	2 10 0	
„ Postage	10 11 7	
		97 8 9
„ Railway Tickets (Deposit Account)		33 6 8
„ Balance at Bankers ...	92 6 10	
„ Petty Cash in hand ...	1 2 6	
		93 9 4
		£1,773 0 8

Audited and found correct, { J. W. WASHBOURN. J. B. LEATHES.

May 3rd, 1894.

Sport.

Association Football.

REPORT OF SEASON 1893–1894.

THE Association Football Eleven have had a decidedly better record than had been anticipated at the end of last season. This is due to the arrival of some first-class new men at the Hospital, and also to increased keenness on the part of the old hands. Here are the figures of the season's work:—Matches played, 24; won, 14 lost, 6; drawn, 4. Goals for, 59; against, 43.

This is a great improvement on last year, when the wins and losses nearly balanced. Four of our six defeats were lost by the bare margin of a goal, so that with a little luck our record would have been even better.

Our first match was against Beckenham, who are now a very strong team, including in their ranks, among other well-known players, our old goal-keeper, Bolus. We beat them, after a great game, by 2—1, a performance we look back upon with some pride, as we were the only hospital who beat them this year.

On October 25th we went down to Marlow, and although it was a Wednesday match, we were able to take down a team good enough (although without our captain) to beat this powerful club by 2—1, a win which rather opened the eyes of a well-known Bart.'s half-back to our increased strength this year.

Our annual match at Eastbourne was fixed for November 18th, but at the last moment one of our best men was unable to go down with us, and as we could not get a substitute, we had to take the field with only ten men—a defeat of 3—0 was not bad under the circumstances, as Eastbourne were only beaten twice last year (once by the Corinthians). Needless to say, we were entertained most hospitably afterwards by H. J. Holman, who did so much for the "Soccer" Club when he was at Guy's. We take this opportunity of thanking him for the many kindnesses we have received at his hands during the past few years.

A good win over Wolverton was the only other event of importance during the first half of the season.

At the beginning of this year the team soon got together and settled down in earnest for the Cup ties. The first of these was against Surbiton Hill in the second round of the Surrey Cup—Barnes having been disposed of in the first round easily by 7—1. This was played at Honor Oak Park, and although the ground was very soft and a tall wind blowing, we beat them by 3—0. This gave us great hopes for our tie with St. Mary's in the first round of the Hospital Cup—but, alas, they beat us by a goal to nothing, chiefly brought about by their superior combination and several of our men receiving severe injuries. Mary's were drawn against Bart.'s in the second round, but before they met, Bart.'s raised a protest against one of the Mary's men. A U.H. meeting was called, when, as is now well known, the Mary's man was disqualified, and they were ordered to meet Bart.'s without him. St.

Mary's, in a most sportsmanlike manner, now decided to replay Guy's again without him; Bart.'s objected to this, but, on being put to the meeting, it was decided that Guy's should meet Mary's again. So we did, and this time, with a somewhat re-organized team, we beat them easily by 4—0.

Then we met Bart.'s in the second round on our own ground, and, in the presence of a good crowd, beat them by 1—0.

University College were met in the semi-final and beaten by 2—1. The final was played at Leyton, between Guy's and Middlesex, when Guy's triumphed by 4—1, and thus brought back the Cup after an absence of five years. Long may it remain with us!

In the Surrey Cup we had been drawn against Weybridge (holders) in the semi-final, and went down to Walton, accompanied by four other Guy's men, in the expectation of being badly beaten by so strong a team, which drew its men from all parts of Surrey and half Middlesex. We played up in a most surprising fashion, better than we have ever done before or after, and beat them by 3—2, after a most exciting and well-fought game. We now reached the final, and had to meet Reigate Priory, at Guildford. Reigate have won the Cup five times, and have been in the final four other times. Guy's have won the Cup twice, and been in the final two other times.

We should have beaten them, but only managed to draw one all after two hours' play. Meeting a fortnight later, we got badly beaten, 4—0, our men being obviously stale and out of condition.

Turning to the players, Lavers in goal has done yeoman service; he has expressed his intention of retiring before next season. We shall be very sorry to lose him, and hope he will reconsider his decision. Carter and Lidderdale have played some splendid games, notably the former, against Weybridge; the latter against Reigate in the final. May they be as good next year. The halves have been Crosby, Cooper, and Daniel, and it would be hard to give them too much praise. Daniel's play in the first Reigate match, and Cooper's against Weybridge, will not be easily forgotten by those who saw it, while Crosby has been consistently good all through the season. Hewetson has played both half-back and forward, but the former position is the one where he is seen at his best. He has made a most excellent captain, both on and off the field; we congratulate him on the successful issue of the season, due, in no small measure, to his able management of the team. The forwards have had their days off, but have, on the whole, played much better than they did last year. They shone most in the Weybridge match, when they played with much more dash than they usually did. Stamford and Walker deserve special mention for their play, and it was hard lines for the latter to be too unwell to take his place in the final Cup tie. Hibbard did good work in the Hospital Cup ties, and Humphrey, on more than one occasion, has shewn promise of good form—we shall watch him with interest next year.

The following are now out of their year—H. Hewetson, A. M. Daniel, and C. E. Hibbard. We hope some good men will be forthcoming to take their places next season.

The honour caps were awarded to N. Lavers and R. B. Stamford.

The following officers have been elected for next season:—Captain, R. T. Fitz-Hugh; Hon. Secretary, F. J. Lidderdale; Committee, A. E. Crosby, N. Lavers, A. B. Carter, R. B. Stamford, H. Hewetson.

Cricket.

GUY'S v. MITCHAM.

Played at Mitcham on Saturday, 26th May—a horrible day for cricket—with a strong wind blowing, and occasional snow showers. Francis lost the toss, and Mitcham went in, but quickly lost three wickets for only 12 runs. Then Harvey and Rhoades got together and began forcing the game, and added 105 runs before Harvey was out to a good catch in the deep field. Rhoades should have been easily run out when he had made about 15; but for some occult reason the bowler did not put the wicket down, though Rhoades had given up all hope of getting back. He was at last run out through a smart piece of fielding on the part of Wilson. The last five wickets only added two runs, Trouncer taking four wickets in four balls, and the fifth man was excellently run out by Stamford.

Our first four wickets only produced 15 runs, but Stamford and Trouncer batted very well, and added 80 runs when Trouncer was run out—a very questionable decision. He had hit freely and well for his 47, and this decision undoubtedly lost us the match. Stamford was out directly after for a most useful 30. Of the rest Pike alone reached double figures, and the total only amounted to 129, leaving Mitcham victorious by 15 runs. Score:—

MITCHAM.

H. Pillinger, c Nicholls, b Joyce	3
H. Hazell, run out	5
N. Harvey, c Wilson, b Trouncer	59
J. Caffarey, b Joyce	0
W. Rhoades, run out	42
W. Hambling, b Trouncer	12
A. Clarke, not out	1
Edgar, b Trouncer	0
F. Harris, c Alexander, b Trouncer	0
W. Hussey, run out	0
J. Keene, b Trouncer	0
Extras	22
Total	144

GUY'S.

C. J. Francis, c Pillinger, b Hussey	4
F. J. Nicholls, c Pillinger, b Keene	8
C. A. Trouncer, run out	47
A. H. Wilson, b Keene	1
J. H. Joyce, c Hussey, b Keene	0
R. B. Stamford, c Keene, b Caffarey	30
A. Perks, c Rhoades, b Keene	6
N. Pike, b Hussey	16
B. B. Ham, b Keene	0
K. B. Alexander, not out	4
E. G. Goddard, b Keene	1
Extras	12
Total	129

GUY'S v. EALING.

Played at Honor Oak Park on Wednesday, 30th May, For a change it was fairly warm, but the wicket was very dead after the rain. Francis won the toss, and commenced batting with Nicholls, who, however, left early, after scoring 3. Shorland and Trouncer did nothing much, but Perks stayed with Francis, and they put on 55 for the fourth wicket, when Perks was out for a useful 21. The next three wickets only added 12; Francis was out seventh for a very careful 37. Prince and Alexander hit out lustily and added 44 for the last wicket, the former hitting four 4's and three 3's in his 32.

During lunch rain fell heavily, and made the wicket very easy, and when the score reached 60 for only one wicket things did not look too bright for us; but the ground was drying fast, and after the second wicket fell there was a regular procession, and the total only reached 108, leaving us winners by 46 runs—our first win. Shorland took five wickets for 46, Hancock four for 24. The fielding was excellent, and Alexander kept wicket very well. Score:—

GUY'S.

C. J. Francis, c Gooding, b Rooke	37
F. J. Nicholls, b Bascombe	3
C. A. Trouncer, c Gilbert, b Bascombe	8
E. T. Shorland, b Bascombe	5
A. Perks, b Rooke	21
W. J. Hancock, b Bascombe	12
A. H. Wilson, b Rooke	5
R. B. Stamford, b Chillman	2
N. H. Pike, b Rooke	1
P. C. Prince, not out	32
K. B. Alexander, b Bascombe	15
Extras	13
Total	154

EALING.

S. F. Wood, b Trouncer	2
T. Gilbert, c Alexander, b Shorland	31
S. J. Hill, lbw, b Hancock	27
— Chillman, c Trouncer, b Hancock	8
C. Bascombe, b Hancock	7
E. Jowitt, c Nicholls, b Shorland	0
G. McCree, C. Prince, b Shorland	6
F. Jeboult, c Wilson, b Shorland	0
— Gooding, b Hancock	2
— Rooke, b Shorland	16
H. Walton, not out	1
Extras	8
Total	108

Sporting Notes.

CRICKET.

THE Cup Ties commenced with two matches on the Clubs' Union ground, the first round resulting as follows:—

A. St. Bartholomew's beat London by 178 to 100, May 31st.

B. St. Mary's beat King's by 93 and 107 (for three wickets) to 104 and 95, June 1st.

The other Hospitals drew byes.

The second round is drawn as follows:—

St. Bartholomew's v. St. Mary's, Tuesday, June 19th.
St. Thomas's v. Westminster, Thursday, June 14th.
Guy's (Holders) v. Charing Cross, Tuesday, June 12th.
Middlesex v. University College, Friday, June 15th.

The Guy's Eleven, though on paper a very powerful batting team, have not done so badly for some seasons, and have only won one match so far—over Ealing—suffering defeat at the hands of Beckenham, Surrey Club and Ground, and Mitcham; the matches against Crystal Palace and Repton School having been unfinished. The composition of the Eleven has undergone a good many changes, and should be definitely settled very soon, if we are to make a good show in the Cup Ties. The greatest source of weakness is, however, in the bowling department. Shorland has been doing good work, notably at the Oval, where he was at his best; bowling right through the Surrey innings, he seemed always difficult to play, and captured eight of our opponents' wickets at the cost of 9·5 runs apiece. Hancock in this match manifestly showed the weakness in his knee, which, we are glad to learn, is getting stronger every day, and will enable him soon, no doubt, to get into form. Of the others, Pike has been useful as a change bowler, Trouncer has been unable to play as often as desirable; he met with much success against Mitcham, taking five wickets for 35 runs, four of them with successive balls. Joyce will be able to assist the Hospital in the Cup Ties, and will materially strengthen the team. As far as fielding is concerned, nothing better could be wished for.

Since writing the remarks about the composition of the Eleven, we are assured that the chief difficulty met with is in getting the men to play in so many out matches regularly—a difficulty which can only be appreciated by the Selection Committee, and which it is hoped will soon be remedied.

SWIMMING.

The Guy's Hospital Swimming Club held its annual meeting on Tuesday last, when the following were elected officers for the ensuing season:—President, A. D. Fripp, Esq.; Vice-President, J. H. Tubby, Esq.; Captain, W. R. Wood; Hon. Secretary and Treasurer, V. E. Collins; Committee, Messrs. Payne, Simpson, Clarke, Dudgeon and Hardy.

The Club, not yet affiliated to the Clubs' Union, is in a fairly satisfactory condition; and though a very poor show was made by the Polo team last year against Middlesex, when we turned up one short in a replayed tie, things should be different in future. Guy's, one of the first to join in the United Hospitals' Swimming Club, has not done itself justice in this department of sport, in spite of the large number of really excellent swimmers there are in the Hospital. Of the Polo matches arranged with other clubs nothing can be said, except in connection with the energetic secretary in arranging them; but a more than ordinary team could be got together it is

certain, if only interest and energy were not restricted to committee-men and officials. The head-quarters of the Club were located last year at the Buckingham Palace Road Baths, and this may have in part accounted for the very poor attendance. We have lately heard of the Camberwell Baths, newly opened last year, within thirty minutes of the Hospital, which might possibly be more suitable and convenient for Guy's men—a suggestion which might be inquired into by the new committee.

TENNIS.

Owing to the inclemency of the weather Tennis has been at a discount of late, but some progress has been made with the annual tournament, in which Dudgeon and Alabone seem to have made the running so far.

The Cup Ties begin shortly, and with such men as Webb, Stoker, and W. J. Hancock in the six, Guy's should have no difficulty in again winning the Cup. Stoker has already been performing grandly in the International Contest between Ireland and England, held at Dublin last month. In the singles his performances were among the best of the afternoon; he was in great form, winning against E. G. Meers by 6—3, 6—1, 6—1. In the doubles, associated with J. Pim, all three matches were won against the Brothers Baddeley, 6—4, 8—6; Messrs. E. W. Lewis and E. G. Meers, 6—2, 6—2; and Messrs. E. Renshaw and H. S. Barlow, 6—3, 6—0. In the Irish Championship the same pair—holders—defeated E. W. Lewis and C. H. Martin, 6—3, 7—5, 6—4.

The Tennis Ties, fixed for June 13th, have been drawn as follows:—

A. Guy's v. King's.
B. St. Bartholomew's v. St. Thomas's.
C. Middlesex v. London.
D. St. George's v. Charing Cross.

The team will be selected from the following:—W. J. Hancock, E. D. Hancock, A. V. Clarke, G. B. Webb, B. P. Pendred, H. W. Dudgeon, A. B. Carter, A. H. Partridge, and T. Tulk-Hart.

At the invitation of Dr. Sturge, an old Guy's man, the first team played at New Eltham on Saturday, gaining an easy victory by five events to one. Webb lost his single, playing in very poor form. A. V. Clarke and E. D. Hancock played brilliantly. A. B. Carter played for us for the first time, and showed very good form.

ATHLETICS.

The Guy's Sports are announced to take place at Stamford Bridge on the 21st inst. Intending competitors are reminded that entries—the number of which at present is *very* small—close to-day. It is to be hoped that the weather, by no means the least important item in the day's sport, will prove an exception to what appears the rule just now, that the goodly company expected to view the "meeting" may have every chance of a pleasant outing. There are no new features in the programme this year; and though Guy's still have Munro, Bell, Lowe, Scott and Batchelor to represent them, "freshers" and others, yearning to do battle for the Champion Hospital, must not despair of a place in the representative team.

Guy's Hospital Rifle Association.

THE match against Dulwich College was shot on Wednesday, May 30th, at Bromley, and resulted in a win for our opponents by fifty-two points. The commencement was delayed by a heavy storm, which washed all the paint off the targets, and necessitated further application of the brush. The rain soon ceased, however, leaving a fair light, which, though dull, was steady.

At 200 yards it was soon evident that we were going to make Dulwich a present of the match, and on going back to 500 they led by forty-one points. A somewhat fickle right wind now made itself apparent with marvellous results—more particularly to our team—though several of the Dulwich men failed to shoot up to their 200 yards' form. As a matter of fact the bull—comforting sound to the firer—was found more often by our men than theirs, but they further increased their lead by eleven points, making a total of fifty-two to the good.

Score:—

	GUY'S. 200	500	Aggregate.
A. Scott-Turner ...	22	21	43
C. B. Sells ...	32	22	54
R. H. Ashwin ...	22	28	50
W. B. Secretan ...	27	22	49
P. S. Mandy ...	26	23	49
G. H. Bedford ...	8	0	8
W. H. Telling ...	25	16	41
H. Fulham-Turner	26	30	56
			350
	DULWICH.		
L. C. French ...	28	26	54
H. S. French ...	29	23	52
C. M. Burmester ...	30	27	57
E. Tompkins ...	28	27	55
G. E. Clark ...	32	17	49
D. H. Trail ...	27	10	37
E. S. Phillips ...	29	15	44
N. Carpmael ...	26	28	54
			402

PRIZE COMPETITION.

A prize competition will be held at Ilford on Tuesday, June 12th. The handicaps and entrance fee are posted in the colonnade. Conditions:—Ranges 200, 500 and 600 yards, one sighting shot and seven rounds at each range. The competition commences at 2 p.m. sharp, and men are requested to go down by the 1.15 p.m. from Liverpool Street.

Birth.

LANSDOWN.—At 39, Oakfield Road, Clifton, Bristol, on May 15th, the wife of Robert G. Poole Lansdown, M.D., of a son.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

JUNE 23, 1894.

Suppurating Hydatids in the Liver. Drainage, followed by Emaciation and Lethargy.

CLINICAL LECTURE BY DR. NEWTON PITT.

(Clinical Notes by Mr. C. L. HOPKINS.)

"AMY W., æt. 32, says she felt a lump in her side before the birth of her last child, fifteen months ago. Towards the end of April she was frightened and next day she noticed she was slightly yellow, and complained of severe pain in the right side, when her liver was found to be enlarged. Since then she has had paroxysmal attacks of pain in the abdomen.

"When admitted on May 16th she was thin, anæmic, barely jaundiced. Temperature 101°; pulse 100. The upper limit of the liver was normal, and the dulness extended down seven-and-a-half inches in the nipple line. To the left of the umbilicus a notch with an ill-defined projecting mass (A) was palpable. There were no irregular projections on the anterior surface of the liver. The spleen was not enlarged; there were rhonchi audible over the chest. The liver was free from tenderness and pain."

When the hepatic dulness is bounded above by a line concave upwards, and is higher behind, it indicates disease; also in either the pleura or diaphragm, produced by fluid or solid.

When, as in the present case, the line is convex upwards, and the dulness is higher in front than behind, it indicates disease below the diaphragm. The dulness may, when there is an abscess or hydatid on the upper surface of the liver, reach up to as high as the third rib in front. The increased dulness in this case, which is continuous with that due to the liver, may be due to:

1. Lardaceous disease.
2. Displacement.
3. Congestion.
4. Leuchæmia.
5. Cirrhosis, whether alcoholic or malarious, etc.
6. Gummatous infiltration.
7. Cancer.
8. Impacted gall-stones with distended gall-bladder.
9. Hydatid.
10. Abscess.
11. Subdiaphragmatic abscess.

The attacks of intense pain exclude the first five of these. The smooth surface of the liver, and the healthy condition of the spleen and kidneys, excludes (6). The fact that the rounded mass is to the left of the umbilicus, makes (8) improbable, but no definite diagnosis as to the actual lesion was arrived at.

"Four days later a pleuritic rub was audible towards the right axilla. The temperature became more irregular, running up to 103·6°, and the tongue was red with prominent papillæ. The anæmia increased.

"On May 22nd a distinct globular tense swelling was apparent in the region (B) below

the ribs on the left side. The stomach resonance lay to the left. This swelling was explored with a needle, and, as suspected, was found to contain pus.

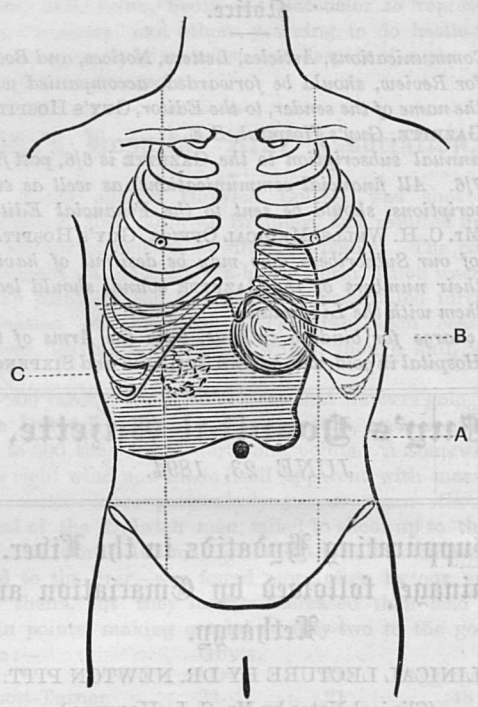
"Next morning Mr. Jacobson opened the abdomen over the swelling, where the liver was found to be adherent to the wall; the abscess which lay near the surface was drained, and the edges stitched to the abdominal wall. Besides laudable pus, granular masses of bile-pigment and a small piece of thin membrane were removed, but no hooklets were found. It was now clear that the enlargement was due to the abscess, and the normal upper limit of dulness made it probable that the abscess was in the liver and not subdiaphragmatic eroding the upper surface."

The most common causes of a large hepatic abscess are ulcerative colitis and hydatids in the liver. Occasionally the cause has been pelvic inflammation, and in a case under my care in 1890, the cause was an ulcerated appendix.

"The patient continued to emaciate, became more anæmic and sallow, perspired profusely, had no appetite, was very drowsy, developed diarrhœa, and the temperature was irregular; the urine contained peptones. On the 26th a fulness in the region (c) became more definite, and it was clear that there was a second abscess."

A doubtful fulness had been noticed at this spot at the first operation, and had due weight been given to the pleurisy on the *right* side, the abscess might have been detected then.

The constitutional evidences of suppuration consist of emaciation, anæmia, a characteristic sallow appearance, weakness and langour, profuse perspiration, a rapid dicrotic pulse, an irregular temperature, diarrhœa, loss of appetite, and the presence of peptones (and often of albumoses) in the urine.



"Mr. Jacobson explored the second swelling, a few drops of thin fluid were drawn off with a syringe, but three punctures were made without obtaining any pus; the surface of the liver, which was very vascular, was not adherent to the abdominal wall, the space between them was packed with gauze, and a drop of pus was then noticed to ooze at one of the punctures. The abscess was opened, and a mass of hydatid skins removed, and it was clear that these had prevented the pus from entering the syringe. The membranes were also completely cleared out of the first abscess."

Of ten recent cases of hydatid in the liver, six were in women; the ages of seven of the patients were between twenty and forty. The history was chiefly that of a swelling noticed for periods of some months, in three cases for a year, and in one for twenty years. In three there were also attacks of severe pain; two were aspirated and went out

relieved; five were drained and granulated up; one of them who came in also suffering with typhoid, died after five days. Three cases which had suppurated were drained, of which one died. The cysts were single in seven cases, in one case there were three cysts in the liver, and in another two in the liver, and one in the spleen.

Hydatids are the cystic form of the tænia echinococcus, a small tape-worm of three or four segments, a quarter of an inch long, which is very common in dogs, and is also found in foxes and jackals. The ova are discharged with the fæces and foul vegetables or water, and thus may be swallowed by human beings. In the alimentary canal, the shell is broken up and the embryo bores its way into the liver most commonly, but it may find its way to any part of the body. It is less clear how the dogs become infected, and whether any other animal can act as a second host; the results of feeding various animals with the scolices from dogs have failed with the exception of some experiments on pigs. Small nodules were found in the livers after some weeks, most of them mere granules, but some larger, and a few formed cysts the size of a nut, but without exception they were barren and did not contain any heads, the question therefore requires further elucidation.

It is rare for a hydatid when not interfered with by operation, and not situated in the liver, to suppurate. This occurs in about a quarter of those in the liver, but the determining factors are still obscure. It appears that it is very likely to take place when there is any communication with a bile duct, but it occurs otherwise as well. The organisms, which are the active factor in starting the suppuration, also require investigating.

"The patient continued to emaciate after the operation, and passed into a very drowsy state, in which she paid no attention to anything, and she lay more or less asleep all day. The pulse was very rapid, and she took but little food by the mouth; she was also fed by the rectum. The tongue was aphthous, and very red. After the first day or so the discharge from the cavities was free from pus, and consisted of gelatinous bile-stained fluid. The local condition of the wounds steadily improved. The urine contained ·8 per cent. of urea. Each day she took her nourishment better, but without any relish. Yesterday was the first time she has taken any interest in her surroundings, and the urea was found to have reached 2·8 per cent., but she is passing but little urine."

Bearing upon this condition of emaciation and stupor following upon the inhibition of the function of the greater part of the liver, the experiments of Hahn and Masser (*Archiv. fur Exp. Path., vol. 32*) are of great interest. These experimenters succeeded in forming a fistula between the portal and inferior vena cava veins in dogs; when the wound had healed they ligatured the afferent vessels of the portal vein, in this way the liver was no longer able to act on the products absorbed by digestion. The effect upon those dogs that recovered was remarkable, the quietest even became ill-tempered, wild and furious. They suffered with tonic and clonic spasms, with symptoms of depression, they were very ataxic, lost weight and appetite, becoming anæsthetic, and finally sleepy and comatose. The temperature was at first subnormal, and then was raised. The urea excretion was diminished, that of uric acid increased. A meat diet at once made the animals worse, and induced a fit, and frequently death.

Carbamate of soda or calcium is probably the toxic body which induces these symptoms. It is produced by digestion and normally broken up by the liver. Introduced into the stomach of a healthy animal the results are negative, but if the liver be removed from the circulation, or if

it be introduced directly into the blood, the above symptoms ensue, viz.—

1. Somnolence with ataxia.
2. Excitation with blindness and ataxia.
3. Catalepsy with anæsthesia.
4. Clonic convulsions.
5. Tonic convulsions.

Roger and other observers have shown what an important function the liver has in destroyed various toxic bodies produced in digestion, and its slighter degrees of failure are familiar to us in the sleepiness and headache which follows after meals, when the liver is out of order; the drowsiness, the absolute indifference, the loss of appetite and the emaciation of this patient are due to the same cause, viz., inhibition of the function of most of the liver cells.

[Since the lecture was delivered, the patient has regained her nutrition considerably; she has recovered her appetite, and has had some chicken, and is no longer so indifferent. Her urea now averages over 2 per cent.]

Notes on Dr. Shaw's Demonstrations in Pathology.

HEART.

Aortic orifice and valves.

(*a*) Four valves (1413[80]). Congenital malformation.

(*b*) Two valves (1413[85]), probably due to disease which has converted two valves into one.

Atrophy of valves (1413[81]). The specimen is from a bronchitic and emphysematous patient; it is a condition of not much clinical importance. The valves usually become thicker with age, but sometimes they do not become thick, especially in emphysema, where most strain is thrown on the pulmonary valves.

(*c*) Injury (1414). It is doubtful whether a healthy valve ever ruptures, since patients with supposed rupture do not die at once, and post-mortem the valves are found to be covered with vegetations.

Aortic stenosis.

(*a*) Obstruction by vegetation (1416[50]).

(*b*) Obstruction by adhesion (1421, 1421[20]).

Aortic stenosis is the least important of heart lesions, because vegetations do not cause very much obstruction, but may give rise to loud bruits; they often become detached and then the bruit disappears. They always appear on the ventricular surface, and more especially on (1) corpora arantii, and (2) in the lunula.

Aortic regurgitation.

(*a*) Valves at fault.

1. Shrinking (1419).
2. Perforated (1418[80]) (ulcerative endocarditis).
3. Adhesion to wall (1418[10]). Sometimes one of the valves adheres to the wall of the aorta.
4. Detachment (1416[80]).
5. Retroversion of aortic cusps (1419[50]). Edge of cusps are turned back into the ventricle; probably this is a result rather than a cause of regurgitation.

(*b*) Orifice at fault.

Dilated orifice owing to dilatation of aorta from atheroma (1483[50]).

Mitral.

1. Congenital malformation (1402, 1402[10]). Sometimes with three cusps, of no interest clinically.

Mitral stenosis, found in young women without any disease to account for it, is sometimes thought to be congenital; on the other hand evidence of stenosis, not often found in infants, may be set up by endocarditis without any definite joint pains.

2. Regurgitation.
   (*a*) Dilated orifice (1427[60]). Most common cause.
   (*b*) Defective valves.
      1. Shrunken.
      2. Perforated (1403[40]) [2]. May have been caused by a large vegetation, flapping back during the diastole upon the aortic side of mitral cusp, and so producing slight ulceration.
      3. Ruptured chordæ (1403[87]). They sometimes give rise to secondary ulceration by moving about in the blood current.
      4. Large vegetations (1407).
      5. Lengthened chordæ.
      6. Aneurysm of valves (1403[48], 1403[56]). As a rule this does not produce mitral regurgitation.
3. Mitral stenosis.
   (*a*) Adhesion and contraction (1405[10], 1405[20]), due to endocarditis, which gives rise to formation of fibrous tissue, and consequent contraction of valves.
   (*b*) Large vegetation (1407) [5]. They cause obstruction by projecting into the blood stream.
   (*c*) Virtual stenosis.
      1. The orifice remains the same size, but the auricle and ventricle on either side are dilated, hence the orifice is relatively smaller.
      2. In case of aortic regurgitation, the blood flowing back in diastole towards the mitral orifice may cause an obstruction and virtual stenosis.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Nervous System.

PHILIP 3. Right hemiplegia. Cerebral syphilis.
9. Chorea. Mitral regurgitation.
18. Cerebral tumour. Optic neuritis.
25. Optic atrophy. Cerebral tumour.
28. Mitral and aortic regurgitation.
32. Ataxic paraplegia.

STEPHEN 10. ? Hysteria. ? Insular ichiosis.
11. Right hemiplegia aphasia.
12. Cerebral tumour. Optic neuritis.
25. Diphtheritic paralysis.
29. Acute myelitis.

MARY 8. ? Peripheral neuritis. ? Locomator ataxy.
9. Optic neuritis. Cerebral tumour.
10. Hysteria.
cot 51. Chorea.
16. Hysteria.
21. Hysterical paraplegia.
17. Chorea. Mitral stenosis and regurgitation.
19. Chorea following acute rheumatism.
35. Insular sclerosis.
42. Diffuse myelitis. Optic atrophy.
44. Locomotor ataxy. Perforating ulcers.

Respiratory System.

PHILIP. 4. Early Phthisis. Albuminuria.
7. Hæmoptysis. Phthisis.
12. Adherent pleura. Bronchietasis. Lardaceous disease.
15. } Phthisis.
21. }
30. Pleuritic effusion.
37. Phthisis. Ascites. Albuminuria.

STEPHEN. 8. Empyema.
20. Bronchitis. Emphysema. Pleurisy.
24. Empyema.
26. Pleuritic effusion.

Mary. 1. }
25. }
31. } Phthisis.
45. }
48. }
44. Pneumonia.

Circulatory System

PHILIP 22. Aortic stenosis and regurgitation, and mitral regurgitation.
23. Aortic stenosis.

STEPHEN 2. Ulcerative endocarditis.
4. Mitral stenosis and regurgitation. Ascites. Pleuritic effusion. Erysipelas.
STEPHEN 13. Mitral stenosis and regurgitation. Aortic regurgitation.
14. Mitral stenosis and regurgitation. Aortic and tricuspid regurgitation. Ascites. Enlarged liver.
16. Mitral regurgitation.
18. Mitral regurgitation and ulcerative endocarditis.
34. Aortic stenosis and regurgitation. Mitral regurgitation.

MARY 11. Mitral stenosis and regurgitation. Adherent pericardium.
26. Aortic regurgitation and mitral stenosis.
36. Aortic and mitral regurgitation.
41. Adherent pericardium. Mitral stenosis and regurgitation.

Alimentary system and disease of abdomen.

PHILIP 7. Enlarged and irregular liver. ? Carcinoma.

STEPHEN 6. Tuberculous peritonitis.
7. Hæmatemesis. Cirrhosis of liver.
19. Tuberculous peritonitis.
31. Dysentery.
33. Carcinoma of pylorus, probably following gastric ulcer.
39. Carcinoma of pylorus.

MARY 2. Gastric ulcer.
3. Perityphlitis.
5. Gastric ulcer.
6. Enlarged liver.
32. Abdominal tumours.
33. Catarrhal jaundice.
38. Gastro jejunostomy.
50. Tuberculous peritonitis.

Genito-Urinary System.

PHILIP 5. Chronic Bright. Pleuritic effusion.
11. Chronic Bright. Left hemiplegia.
19. Diabetes mellitus.

STEPHEN 3. Chronic Bright. Trophic ulcers of feet.
5. Renal calculus.
15. Diabetes mellitus.
27. Chronic tubal nephritis.
40. Chronic Bright.

MARY 4. Hæmaturia. Subacute nephritis.
20. Nephralgia. Nephrorraphy.

Joints.

PHILIP 6. Rheumatoid arthritis.
27. Acute rheumatism.
33. Gout.
34. Acute rheumatism.

STEPHEN 1. }
9. } Acute rheumatism.
30. }
36. }

MARY 12. Acute Rheumatism.
39. Osteo arthritis.

Miscellaneous.

Philip	1.	Hodgkin's disease.
	2.	? Tuberculosis.
	10.	Plumbism. Anæmia. Colic. Blue line.
	35.	Optic neuritis. Retinal hæmorrhages. Tubercular growth of left Iris.
	36.	Tuberculous ulceration of skin.
	40.	Plumbism.
Stephen	23.	Plumbism.
Mary	23.	Typhoid fever, convalescent after two relapses.
	29.	Typhoid fever, convalescent.

Cases under Dr. Pye-Smith.

Mary.

32. S. B., æt. 42, married woman, with sixteen children; no family history of disease.

Scarlet fever when a child, no illness since. Six years ago had pain in the epigastrium, with hæmatemesis; admitted to Bartholomew's Hospital. Two years ago she had swelling of legs, pain in epigastrium, vomiting of blood and vomiting of food. Admitted into Guy's Hospital under Dr. Pye-Smith. She was found to have anæmia, dilated stomach, enlarged spleen, hæmatemesis and retinal hæmorrhages. Temperature 98—100. These symptoms cleared up.

Since then she has had pain in abdomen and hips, occasionally also in epigastrium with vomiting. Has lost one stone in weight. Has been jaundiced (?). Has occasionally passed large quantities of urine. Has noticed for last eight months a tumour in abdomen.

On admission. Temperature normal. She is anæmic, with sallow, rather wasted face. In left part of epigastrium a tumour, with a clearly defined edge, can be felt, probably left lobe of liver. Under this edge can be felt a hard rounded tumour, which appears to be connected. This tumour is extremely tender on pressure. The right lobe of the liver is slightly enlarged. There is pulsation in the epigastrium over the tumour and a systolic murmur can be heard on it.

The spleen can be felt, and is not enlarged appreciably. Both kidneys can be felt. The heart beats irregularly, 60; intermitted and abortive beats; occasional systolic bruit. No retinal hæmorrhages.

Since admission has had a severe attack of pain in the epigastrium, the tumour being very tender. She has pain also in the back, passing into abdomen and hips, accompanied by tenderness over spine.

Philip.

32. J. P., æt. 35. Admitted for weakness of the legs and inability to stand. There is no history of syphilis. The illness began eighteen months ago with stiffness in his right leg. The left leg became involved nine months ago, and now he cannot stand without holding some support with his hands. There are some areas of anæsthesia on his legs. He has increased knee-jerk. Pupils react to light and accommodation. The vessels are more tortuous than normal in the upper part of the right pupil.

Dr. Pye-Smith diagnosed Ataxic Spastic Paraplegia.

Cases Under Dr. Goodhart.

Philip.

1. W. W., æt. 12. Admitted for high temperature and diarrhœa. Patient had scarlet fever three years ago, and soon after he recovered from the attack he had diarrhœa, his bowels being opened often six times a day.

On Admission.—Temperature 101·6, pulse 100, respiration 32. Abdomen is distended and rigid; liver and spleen enlarged; enlarged glands felt both sides of neck, also in right axilla and right groin. The chest is flat and barrel-shaped; dulness and small area of bronchial breathing at left apex in front. Temperature ranges between 100—104.

Diagnosis.—? Hodgkin. ? Tubercle.

18. F. G., æt. 24. Admitted for pain at the back of the head. Illness commenced with a pain at the back of the head; pain was paroxysmal and worst in evening and early morning. Patient then had attacks of giddiness and was unsteady when he walked about. Afterwards he had attacks of vomiting, which came on irrespective of food; just before he vomited he was in great pain, and somewhat delirious. Patient has been losing weight. Patient's eyes have been failing him lately; his eyes ache after very little use.

Condition on admission.—Patient has pain at back of head and in frontal region. There is loss of power in the grip of both hands, left weaker than right; no loss of power in the legs. Two terminal phalanges of the fingers on the left hand are numb.

Eyes.—Pupils are dilated, and react to light. Patient has photophobia. There is well-marked optic neuritis. The edge of disc is swollen, obscuring the vessels, which are tortuous. There are a number of white spots on the retina. Noises in the ears. Taste impaired.

Diagnosis.—Cerebral tumour.

Treatment.—Pot. Iod. gr. xx.
Spir. Ammon. Aromat. ℥ xxx.
Infus. Gent. Co. ʒi. t.d.s.

Inter-muscular injections (in gluteal region), Hyd. Perchlor. gr. ½. This was done for six days, but gave the patient so much pain that Ung. Hydrarg. ʒi. is now rubbed into the arm.

Diet—Middle.

The giddiness has become less, the headache is much better, and the optic neuritis has cleared up to a great extent, so that the edge of disc can be defined, and the vessels are only just observed. Patient can also see much better as the optic neuritis has cleared up under mercury. It has been suggested that the tumour is syphilitic; it has also been suggested that the tumour is tuberculous, as the temperature is so high, seldom being

less than 100 in the morning, and rising to 102 or more in the evening. No evidence of tubercle elsewhere.

MARY.

16. E. A., æt. 21. Admitted for hiccough. Patient has been "ill" for over two years, but nine weeks ago she became so weak that she was unable to walk. About this time she had hiccough, and this continued until her admission into the ward. Patient has been ill-treated by her father at home. She is a weakly-looking pale girl, of a neurotic and hysterical nature.

On admission.—She had constant hiccough, and refused to take her milk, letting it run out of her mouth and refusing to swallow it. She would not speak until threatened with the battery.

The hiccough has now quite disappeared, and patient answers questions in a way.

Circulatory and respiratory systems normal. Eyes react to light and accommodation. Discs normal. Temperature normal.

CASES UNDER DR. HALE WHITE.

MARY.

6. S. P., æt. 22. Admitted on June 1st for dyspnœa. She had been ill for a fortnight, during which time she had been under medical observation. The medical man who sent her up thought she was dying, but could find no physical signs. She had been very dyspnœic, and her temperature had been high. She had never been seriously ill before, except that during last winter she had suffered from "indigestion."

On admission.—She looked ill; temperature, 101·4; respiration, 60. The breathing was shallow, and was more rapid when patient knew she was under observation, when she frequently had paroxysmal attacks of dyspnœa, with choking gasps. She was slightly livid, the complexion was dusky, and the face occasionally flushed—dusky red. The skin felt hot and dry on admission, but afterwards she sweated considerably at times. She suffered from no pain. She was subjected to a most complete examination, but there were absolutely no physical signs; the lungs, heart, abdominal organs, pelvic organs, bones, joints, mouth, throat, eyes, &c., were most carefully examined; the breath sounds were rather louder on the left than the right; the throat was dry and congested, the tongue furred. Dr. Hale White made a V.E., and found the hymen ruptured. Dr. Horrocks was asked to see the patient, and reported:—"I do not think her condition is due to anything pelvic."

Dr. Hale White discussed the diagnosis, which he thought lay between the three following:—Hysteria; acute miliary tuberculosis; pyæmia.

He pointed out that our aim should be to prove that the illness was not hysteria. A diagnosis of hysterical fever should never be made on a first examination, for it was very rare, very easily confounded with other conditions; and such an error in diagnosis was most disastrous. The eyes were carefully examined for tubercles in the choroid, the bones, etc., for some seat of suppuration, with the result above mentioned.

There was no doubt that the girl was neurotic, because:

1. The respirations were quite out of proportion, in rapidity, to the temperature (102—103).

2. The patient had paroxysmal hysterical attacks when observed.

3. Her general behaviour was very suggestive.

On the other hand, the fact that she looked livid, and had a high temperature, was very much against the view that *all* her trouble was neurotic, although a neurotic temperature, however, had been observed in several rare cases.

It was impossible to make a diagnosis before having the patient under observation for a considerable time.

On June 2nd, 3rd, 4th, her condition remained very much the same. It was observed that during sleep respiration was still rapid (60). She looked worse, however, and the lividity was marked, but notwithstanding repeated careful examinations, no physical signs were discovered; the eyes were examined daily, but no tubercles were seen.

5th. On the right side, in front, fine crepitating râles were heard below the second rib down to the sixth in front, and from high up in the axilla down to the ninth in the axillary line.

Dr. Hale White saw the patient and diagnosed acute miliary tuberculosis on the strength of these physical signs, and called attention to the following points:—That acute miliary tuberculosis was clinically quite distinct from ordinary phthisis, as was shown, but its very rapidly fatal character, by the fact that the local changes set up by the tubercles in the lungs were usually so slight that the physical signs were few, although the toxæmia was intense, and the tubercles were present in myriads throughout the lungs, and were usually found in other organs also.

6th. Patient looked decidedly worse, was very livid, and there were no hysterical paroxysms. It was pointed out that when severe organic disease was, early in its course, complicated with hysterical manifestations, they become less marked as the disease progresses. Râles were not so marked, but in places the breathing had a hollow character and could almost be termed tubular.

7th. Patient had pain in the left side; no rub was audible.

8th. Râles were audible in front and behind on the right, and in front on the left side. Patient progressively getting worse. More livid.

9th. A rub was audible low down on the left side.

10th. Patient died.

Since admission, the temperature ranged between 102 and 106, falling on the 9th.

Post-mortem.—Both lungs were studded with miliary tubercles, and the apex of the left lung had commenced to break down. Tubercles were abundant in the kidneys, some were observed beneath the capsule of the spleen. There was some recent lymph on the pleura at the base of the left lung. There was a recent good-sized hæmorrhage at the base of the left lung, probably due to an

infarct, as there was ante-mortem clotting on the right side of the heart. *No caseating glands* were found anywhere.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ACCIDENT.

C. C., æt. 2½. Ruptured urethra. Slight extravasation. External urethrotomy.

A. K., æt. 44. Knocked down by engine. Ruptured rectus abdominis muscle.

J. C., æt. 21. Compound fracture through surgical neck of humerus.

NAAMAN.

W. K., æt. 53. Growth right side of neck; malignant. Hoarseness. Right pupil smaller than left. Pressure on trachea.

R. H., æt. 20. Double inguinal hernia. Retained testis in right inguinal canal. Irreducible omentum in left sac.

S. V., æt. 18. Polypus of rectum. Hæmorrhoids.

H. S., æt. 42. ? Glanders. Amputation of hand.

J. B., æt. 46. Caries and necrosis head of humerus. Excision.

CHARITY.

R. C., æt. 64. Discharge from umbilicus. Induration round umbilicus.

S. F., æt. 5. Pulpy elbow. Excision.

S. K., æt. 38. Strangulated femoral hernia. Operation.

L. S., æt. 49. Scirrhus mammæ.

E. H., æt. 44. Soft carcinoma mammæ.

E. B., æt. 64. Scirrhus mammæ.

CASES UNDER MR. DAVIES-COLLEY.

CORNELIUS.

S. M., æt. 35. Fractured patella. Was fractured at commencement of year and wired; refractured recently; was able to walk about to a slight extent afterwards, the wire probably retaining fragments in apposition.

LYDIA.

R. B., æt. 2. Scald of mouth and throat from boiling water. Blebs on tongue, palate and tonsil. Croupy. Recovery.

M. W., æt. 54. Fractured ribs. Slight emphysema.

S. H., æt. 73. Strangulated femoral hernia (Richter's hernia). Kelotomy.

C. C., æt. 13. Abscess in buttock and thigh. Operation. Necrosis on outer side of ischial tuberosity.

I. J., æt. 48. Proptosis. Sinus below inner canthus; rhinorrhæa. Portion of superior maxillary bone removed three years ago. Bone necrosed.

M. N., æt. 49. Fractured patella. Wired.

S. B., æt. 53. Varicose veins. Ulcer. Phlebitis. Abscess.

B. A., æt. 20. Tubercular caries of sternum. Scraped.

H. G., æt. 22. Lupus. Tubercular abscesses.

LUKE.

J. T., æt. 50. Injury to elbow. ? Fracture into joint. ankylosis. Adhesions broken down under anæsthetic.

S. J., æt. 26. Strangulated inguinal hernia. Congenital. Operation.

A. K., æt. 18. Tubercular epididymitis. Iliac abscess. Pain in spine and over crest of ilium. Flexion of thigh. ? Dorsal caries.

P. S., æt. 48. Hydrocele. Enlargement of testicle.

T. S., æt. 13. Lupus of perinæum and thigh. Scraped.

CASES UNDER MR. LUCAS.

JOB.

2. J. R., æt. 35. Admitted with the following history: Whilst assisting at a fire and holding a hose, a slate fell and struck him, by its edge, on the back of the right wrist; he immediately felt his hand to be weak, but was able to continue holding the hose for two hours afterwards.

On admission.—There was some bruising of the back of the wrist and a slight wound, about half an inch long, not involving the whole thickness of the skin. He was quite unable to extend the first, second or third fingers. Mr. Lucas made a vertical incision four inches long on the back of the wrist, and found the extensor indicis and all the extensor communis tendons cleanly divided just at the lower edge of the posterior annular ligament. The tendons were united by catgut sutures, the wound closed, and the hand and fingers put up in a position of hyper-extension.

The interesting feature of the case was the fact that the tendons were so cleanly cut through without the skin over them being divided at the same time.

22. R. M. W., æt. 47. Admitted June 2nd for hæmorrhoids and hydrocele. Patient had suffered from chronic constipation for some years, and on two separate occasions had had prolapse; had often passed blood with his motions, and for last three years had been obliged to use enemata.

The swelling in the scrotum first noticed four years ago, caused only a slight pain, had steadily increased since, and had never been tapped.

The right side of the scrotum measured 5½ inches by 3½ inches, was tense and translucent, but rather opaque about half-way up behind where the testicle was thought to be. The testicle could not be felt.

On rectal examination, the finger was tightly gripped by the sphincter, the mucous membrane was found to be lax and in folds. There was no prolapse.

On June 5th patient was operated on and the scrotal tumour dissected out. Fourteen ounces of clear fluid was drawn off. This was opalescent on standing, and on microscopical examination was found to contain spermatozoa. On opening up the sac, the testicle was discovered at its lowest part, and still connected with it were some smaller spermatoceles. One of the cysts contained one and a half ounces of straw-coloured fluid, and turned out to be a small hydrocele of the tunica

vaginalis. The cysts were all evacuated, and their sacs cut away. The hæmorrhoids were then treated by the clamp and cautery. Patient never had a rise of temperature; the scrotum healed by primary union. He got up on the thirteenth day, and went out the fifteenth day after the operation.

J. B., æt. 47. Phimosis. Circumcision.

H. S., æt. 10. Tubercular hip.

A. G., æt. 26. Old fractured patella. Wired. Returned to have wired removed.

A. G., æt. 35. Old empyema. Opening into lung. Extensive purulent collection round opening in chest. Free opening made.

J. B., æt. 44. Cystitis. Prostatic calculi. Lithotrity. Several operations.

J. W., æt. 60. Stricture urethræ. Symes' urethrotomy. Glycosuria.

N. K., æt. 23. Cryptorchid.

F. G., æt. 51. Malignant stricture of œsophagus. Bougies passed.

CHARITY.

5. A. G., æt. 22. Admitted June 4th for incontinence of fæces. Three months ago she first had to strain in passing her motions, and these she noticed were flat and small. She was then examined by a medical man who could find no stricture. For six weeks she had passed fæces involuntarily. These were always fluid, and on several occasions contained blood. She had suffered much pain during and after defæcation. On rectal examination, a hard nodular mass was felt immediately above the sphincter. This could be traced up to an annular projection from the wall of the rectum, about two inches from the anus, producing a tight stricture through which the finger could not be passed. The growth bled after manipulation, and Mr. Lucas at once pronounced it to be epitheliomatous. There was no abdominal distension.

On June 19th patient was examined more carefully under an anæsthetic, and as Mr. Lucas found he could get well above the growth, he proceeded to excise the rectum. This structure was dissected away from the surrounding tissues, cutting through the sphincters and levator ani. In front, the posterior wall of the vagina was found to be free from growth, and in dissecting it away from the rectum, the pouch of Douglas was opened. The peritoneum was not infected by the growth, and after being irrigated with 1 in 40 carbolic lotion was sewn up with fine catgut continuous sutures. Three inches of the rectum had to be removed to clear the growth. The bowel was drawn down and fastened on each side and behind to the cut margin of the skin by interrupted fishing-gut sutures. In front the wound was left open and packed with iodoform gauze, after being dusted with tannic acid and iodoform powder. Patient was put on milk and opium gr. ½ 4tis horis.

E. W., æt. 34. Varicose veins.

LYDIA.

D. B., æt. 2 months. Congenital talipes varus.

CASES UNDER MR. GOLDING-BIRD.

CORNELIUS.

G. W., æt. 4. Dislocation forward of head of radius.

MARTHA.

V. L., æt. 5 months. Congenital deformity. Six fingers on each hand; six toes on each foot.

K. Q., æt. 9. Lupus of face.

P. H., æt. 16. Hæmaturia. Pain in loin, shooting down thigh. ? Stone in kidney.

E. S., æt. 29. Swallowed hydrochloric acid. Vomiting after food. No marked constriction of œsophagus. ? Pyloric obstruction.

H. C., æt. 47. Ankylosis of jaw, following necrosis. Removal of wedge-shaped portion of horizontal ramus.

L. W., æt. 14. Sacro-iliac disease (early). Joints explored. Evident tubercular mischief.

J. C., æt. 14. Right genu valgum; left genu varuum. Ogston's operation on right knee.

LAZARUS.

W. L., æt. 18. Alveolar abscess. Ischio-rectal abscess.

E. R., 16. Pain in groin. Lump felt in iliac fossa. ? Appendicitis.

H. B., æt. 58. Epithelioma linguæ. Jaw divided. Tongue and floor of mouth removed.

A. W. B., æt. 24. Swelling and fixation of ankle, following sprain. ? Tuberculosis.

C. P., 56. Dysphagia. Dyspnœa. Hard swelling in right side of thyroid gland. Primary malignant disease of thyroid.

H. H., æt. 17. Abscess in thigh, following kick. Subsequently abscesses have developed in left calf, right arm, etc.

CASES UNDER MR. JACOBSON.

NAAMAN.

J. B., æt. 67. Inguinal hernia. Hydrocele. Radical cure.

W. P., æt. 62. Chronic ulcer of leg. Amputation.

CASES UNDER MR. SYMONDS.

MARTHA.

M. J., æt. 22. Congenital syphilis. Necrosis of nasal bones. Cleft palate. Interstitial keratitis. Deafness. Came in to have defect in palate repaired.

S. L., æt. 22. Symptoms of renal calculus. Nephrotomy.

JOB.

J. P., æt. 29. Loose cartilage in knee.

LUKE.

H. G., æt. 48. Locomotor ataxia. Perforating ulcer. Amputation of great toe.

CASE UNDER MR. LANE.

DORCAS.

M. S., æt. 24. Ovarian cyst.

With Dr. Perry in the Skin Department.

1. A girl, about eleven years of age, brought by her mother on account of spots on her face. Three years' history. Face first affected, then the forearms. On examination, spots seem to consist of small tufts of dilated vessels. This condition, quite apart from anything of nature of acne rosacea, known as telangeiectasis, must be clearly distinguished from congenital dilatation of vessels, or nævus. *Prognosis.*—Apt to get worse, become more closely set, and so produce appearance almost of permanently flushed face, indeed this is what some patients complain of. Treatment is somewhat hopeless (Ung. pro placamine). The spots were chiefly situated below inner canthi and on bridge of nose; they were about size of a pin's head.

2. Procession of families, child-members of which have yellow, heaped-up scabs disposed in more or less circular patches about face. Two children had superficial whitlows on fingers. "Wherever they touch they seem to get it," says the mother. A little girl had some red patches, on which scabs were not markedly present, and one patch was covered with dry scales—passing question of psoriasis, but lesion not present on any other part of body. Boy, æt. ten years, has yellowish crusts about meatus of ear and on adjacent cheek, none behind ear. Eczema rather than impetigo, because obvious cause for former in presence of discharge from ear. Of course otorrhœa may cause dermatitis, which readily becomes pustular from secondary inoculation. *Treatment.*—Ung. Metallorum.

3. Baby with very diffuse lesion. Pustules on hands and red papules on body. Scabies.—When you see actual pustules, not the scabs of impetigo, in a child, think of scabies.

4. Young woman shows red area of skin on back of leg at upper part of calf. Somewhat tender on manipulation. An infiltrating lump; softening at one part can be felt. Gumma. She has been married four years, has had three children, all now dead; the last two were stillborn. Specific treatment.

5. Baby brought on account of papular eruption on arms and trunk. "Comes up like heat bumps, and itches something terrible." This very characteristic history; no wheals to be seen at present. Urticaria papulosa. Treatment.—Liquor Picis Carbonis c. Plumbo ʒj. to Water Oj To be dabbed over skin at night. Mist. Rhei et Magnes. ʒij. t.d.s.

6. Boy with evident pride shows himself cured of Pediculi Vestimentorum by use of Stavesacre Ointment, and plan of sleeping in garment which is worn next to skin during the day; this is repeated for three successive nights. Result: death of all Pediculi.

7. Delicate-looking girl, æt. 21, with severe dermatitis of right leg. Large irregular-shaped bullæ scattered about—moist red surface, well marked off from healthy skin. This fact, coupled with presence of very large vesicles and marked improvement under treatment prior to present relapse, make one strongly suspect that lesion is factitious. The patient was accustomed to work sewing machine with right foot, but has had to give it up on account of eczematous state of leg. It would be interesting to have her in Hospital to be watched. Lesion now several months old. How produced?

Calendar of Coming Events.

June 23rd.—1st XI. v. Mitcham, at Mitcham.
2nd XI. v. H. Hewetson's XI., at Honor Oak Park.

" 26th.—Guy's Hospital Rifle Association v. Harrow, at Harrow.

" 27th.—1st XI. v. Felsted School, at Felsted.
2nd XI. v. University College School, at Honor Oak Park.

" 28th.—Guy's Hospital Christian Union. Missionary Meeting. Dr. Stevenson in the chair. Address by Dr. C. F. Harford-Battersby on "Medical Missions in Africa."
Second Conjoint Examination begins.

" 30th.—1st XI. v. Plaistow, at Honor Oak Park.
Guy's Hospital Rifle Association v. St. Paul's, at Caterham.

July 2nd.—October Appointment List opened.
Last day for sending to Dean Gurney Hoare Prize Essays.

" 3rd.—Applications to Medical Office for Schedules for First Conjoint Examination.

" 4th.—Third Conjoint Examination begins.
Prize Distribution.
2nd XI. v. Blackheath Proprietary School, at Blackheath.

" 5th.—Guy's Hospital Christian Union. Address by Captain Orde Browne, "Guidance as to Work."

Prizes and Medals.

The Treasurer's Gold Medal for Clinical Medicine has been awarded to Mr. J. A. Howard.

The Treasurer's Gold Medal for Clinical Surgery has been awarded to Mr. L. E. V. Every-Clayton.

Fourth Year's Prizes.

The First Prize of £25 has been awarded to Mr. F. J. Steward. Mr. B. A. Richmond has been awarded a Certificate.

Third Year's Prizes.

The First Prize of £25 has been awarded to Mr. W. C. C. Pakes. Mr. N. Daly has been awarded a Certificate.

Passim.

WITH a change in the Editorial staff, we take the opportunity of expressing our hearty thanks to Frederick Gowland Hopkins, for his past services as Editor of the GUY'S HOSPITAL GAZETTE. To his personal supervision, enthusiasm and diligence, the present success of this journal is in a large part due. The striking changes and improvements which have been made in the form and publication of the GAZETTE since Mr. Hopkins assumed the reins of editorship, bear witness to his unflagging zeal on its behalf. Much as we regret his resignation, we trust that his able contributions may not altogether disappear from our columns.

WE are requested to announce that a British Committee, of which Sir Douglas Galton, K.C.B., F.R.S., is the Chairman, and Professor W. H. Corfield, M.A., M.D. (Oxon.), is the Treasurer, has been formed to further the interests in this country of the Eighth International Congress of Hygiene and Demography, which is to be held in Budapest, from the 1st to the 8th of September this year. Any information may be obtained about the Congress from the Hon. Secretary, Dr. Paul F. Moline, 42, Walton Street, Chelsea, S.W.

WE are enabled to announce the names of the successful candidates in some of the prize competitions this year. The entries, especially for the Third and Fourth Year's Prizes, and Treasurer's Gold Medals, have not been so great as might be wished. This is in part due to an arrangement whereby some men, particularly those who take the Primary Fellowship during their third year, are unavoidably, though not necessarily, excluded from the Prize Examinations of later years. Any alteration in this connection, however, is beset with such obvious difficulties, that the present arrangement, while perhaps not entirely satisfactory, is certainly the fairest for all concerned. The wonder is, that knowing this, more conjoint men, among many of whom there seems to be an impression that they have no chance against University and Fellowship men, do not compete in the examinations. Having more time at their disposal, and a relatively longer period in which to work up for their examinations, it is really surprising how few even care to enter; for, be it remembered, that although everyone cannot win a prize, there is no disgrace in being beaten by the man of one's year, and there *are* certificates, by no means to be despised, which, perhaps not of much intrinsic value, are of considerable value afterward as evidence of good work done in the past.

MR. JOHN ALEXANDER HOWARD, to whom our congratulations are due as this year's winner of the Treasurer's Gold Medal for Clinical Medicine, was first connected with Guy's as Assistant to Dr. Stevenson. He obtained the open Scholarship in Science in 1889, and the following year the Second Prize for First Year's Students. He continued to accumulate honours and distinction for himself by obtaining the Prizes for Third and Fourth year's Students, and the Gold Medal and Exhibition in Organic Chemistry at the Intermediate (M.B.) Examination. Mr. Howard is trebly qualified, and obtained the degree of M.B. at the London University in October last, with first-class honours in Medicine and

marks, qualifying for the Gold Medal, and first-class honours in Forensic Medicine.

WE have also to congratulate Mr. L. E. V. Every-Clayton, to whom the Treasurer's Gold Medal in Clinical Surgery has been awarded, Mr. F. J. Steward, who has won the Fourth Year's Prize, and Mr. W. C. C. Pakes, the winner of the Third Year's Prize. All of these gentlemen have already won distinction in their work at Guy's, and we heartily wish them a continuance of their success in the future.

THE first of the Croonian Lectures by Dr. Pavy, on "A new Departure in Connection with Diabetes," was delivered on Tuesday last at the Examination Hall, before the President and Council of the Royal College of Physicians. Our readers are reminded that these lectures are open to all, and those who were fortunate enough to be present at the one under notice must have been more than interested at the observations made by the lecturer. An additional attraction was lent to the occasion by the exhibition of some of the crystals obtained by Dr. Pavy in his original experiments, and which were beautifully presented on a screen by means of a powerful lantern. The last of the lectures will be delivered on the 26th and 28th instant respectively, the whole series consisting of the results and conclusions of our Consulting Physician's searching and exhaustive labours on the carbohydrates, more especially in regard to the treatment of diabetes.

WE noticed with pleasure, at the Annual Inspection of the Corps of Commissionaires, who numbered 1,700 strong on parade, among the seven recipients of the Order of Merit for Long Service and Good Conduct, the name of Commissionaire Hession, who has spent twenty-four years of his life in the honourable service of the Corps, during sixteen of which he has satisfactorily carried out the arduous duties connected with the Students' Cloak Room. Past and present Guyites, who remember the Commissionaire's genial and painstaking methods, will join us in offering him our congratulations on gaining this well-earned distinction.

MRS. ROBINSON and family desire to return thanks to all those who have assisted in securing the election of her son, John Herbert, by their votes and interest, to the Royal Medical Benevolent College, Epsom.

THE Guy's Athletic Meeting, favoured with beautiful weather, held on the first day of summer and longest day of the year, was a success in every way. We do not remember to have seen so large a company present for some years. Amongst the assemblage we noticed Dr. and Mrs. Pye-Smith, Dr. and Mrs. Hale White, Mr. Clement Lucas, Mr. Higgens, Mr. Brailey, Mr. Golding-Bird, Mr. and Mrs. Symonds, Mr. Tom Bird, Mr. Bader, Mr. Dunn, Dr. Bryant, Dr. Fawcett, Miss Newton, and a number of old Guy's men too numerous to mention. A full account will be found at the end of this number in our columns devoted to Sport.

WE understand that the Old Guyite cricket match, inadvertently omitted from the card of fixtures, is to be played at Honor Oak, on July 3rd. Any old Guy's man wishing to play, is requested to communicate with W. J. Scott, 55, Warwick Road, Maida Vale, who has kindly undertaken to make all the necessary arrangements.

OUR readers are again reminded that the Prize Distribution and Biennial Dinner will take place on Wednesday week, July 4th.

Death immediately following a Blow on the Epigastrium.

NO INTERNAL INJURY.—FATAL ENDING FROM SHOCK.

COPY of the report of the case given to Mr. Bryant by Mr. O. Pemberton, of Birmingham, in 1863, in whose practice it occurred:—

"THE FATAL QUARREL IN LITTLE CHARLES STREET.

"THE INQUEST.

"Yesterday afternoon an inquest was held on the body of the lad named George Evans, an office-boy on the premises of Mr. Taylor, machinist and tool maker, Little Charles Street, who resided at Hockley, and who, on Friday morning last, May 7th, 1863, it is alleged, met his death at the hands of a young man, George Jenkins, an apprentice employed in the same establishment, and residing in Icknield Street East. Mr. Filter attended to watch the proceedings on the part of the accused. It appeared from the evidence that the deceased, who was fourteen years of age, was employed in the office of Mr. Taylor as a 'time-keeper,' and Jenkins, who was between sixteen and seventeen years old, by the same person as an apprentice. They had always appeared to be on the best of terms till Friday morning last. Shortly after eleven o'clock in the forenoon of that day Evans went into the workshop to Jenkins and asked for the time he had worked on the previous day. Jenkins refused to give it him till he had finished something he was doing. Evans thereupon said if he did not give it him he would fetch those who would make him. Jenkins said he might fetch who he liked; he did not care. The next thing that attracted attention was a noise and scuffling in the room in which they were. Mr. Taylor then went into the shop and saw them both in the act of fighting. He told them to stop, but before he could prevent them from fighting he saw Jenkins strike Evans somewhere about the stomach. The deceased was crying very much, and went back into the office. Mr. Taylor followed him in, and just as he got near him the deceased cried out, 'Oh! Oh!' and sinking down apparently fainting, died, in about four or five minutes. Mr. Wilkinson, surgeon, had in the meantime been sent for, but before his arrival the deceased had expired. The deceased had some time ago fainted after falling from some boxes in the warehouse. He did not appear much hurt then. Mr. Wilkinson, who had in the presence of Mr. Oliver Pemberton, of Birmingham, made a post-mortem examination of the body, stated that he found no external marks of injury, nor any dislocation of the cervical vertebræ. The heart was empty, and there was some unnatural congestion of the pia mater. In his opinion death had been caused by the shock of a blow in the pit of the stomach. He had heard of death resulting from that cause before, but a case of that sort had never previously come within his experience. From the organic appearances of the body of deceased, he should, if he had no knowledge of the blow, have been led to believe that the deceased died from syncope. George Jenkins, the accused, after being cautioned in the usual way, said that on the day in question Mr. Taylor gave him a screw to repair, which he requested him to get done as quickly as possible. Shortly afterwards Evans came in and asked him for his time of the previous day. He told him that he would give it to him as soon as he had finished the screw. Evans, however, said he would fetch Mr. Taylor, and he told him to do it. Evans was then going out at the door, when he pushed him, which act was returned by Evans, by striking him a blow on the cheek with his fist. A scuffle ensued, during which blows were exchanged, when Mr. Taylor came in and prevented a fight. He (Jenkins) then went on with his work, and Evans went into the adjoining room. Shortly afterwards he was surprised by Mr. Benjamin Taylor telling him that Evans was dead. He then went into the office, and he was sorry to say found his master's statement to be true. He was truly sorry for what he had done, and hoped nothing of the sort would ever occur again. The coroner then summed up, and the jury, after a short deliberation, returned a verdict to the effect that deceased had died from a blow in the pit of the stomach, casually given by George Jenkins. The accused lad was then called before the coroner, who addressed him in suitable terms, and admonished him for his future conduct."

The post-mortem was made May 11, 1863, 96 hours p.m. There was no external mark of injury whatever. No ecchymosis in abdominal muscles.

About three ounces of bloody serum in peritoneal cavity, and about six ounces of partly digested soft food in the stomach; the cavities of the heart were empty, and the blood in the great vessels fluid. There was about two ounces of bloody serum in the pericardium. There was no evidence of internal injury whatever. The vessels of pia mater were congested. Decomposition had advanced with much rapidity.

Case of Perforation of Soft Palate in Scarlet Fever.

AMELIA C., æt. 6 years. Admitted into Eastern Hospital, certified to have diphtheria, on May 7th, 1894. She was said to have had a rash three weeks previously. According to her mother's statement, the doctor who was called in said at first that the child had scarlet fever, but afterwards altered his opinion to diphtheria; the mother said also that the child's "mouth had been ulcerated" for a week before admission.

On admission.—The child was desquamating freely; fauces were covered with thick tenacious mucus, so that it was impossible to say what was the condition of the parts. Child strenuously resisted examination. Some emaciation. Child very ill. Temperature 102.

May 9th. Signs of bronchitis; cough a little "croupy."

10th. A good view of the fauces obtained; there is ulceration of the edge of the soft palate, and slightly of the uvula; in the left anterior pillar is a perforation nearly as large as a threepenny-piece. Excoriation of angles of mouth and anterior nares.

11th. Pulse 160; worse.

12th. Emphysema over both clavicles and over the trachea—on the right side it extends down over the pectoral muscles, and on the left side to the first rib. Slight stridor; dyspnœa increased (perforating ulcer of larynx diagnosed); child died 4.30 a.m. the next day.

Post-mortem.—There was superficial ulceration, irregular, all over the soft palate and uvula, in front and behind. Nearly all the right anterior pillar had been destroyed. The position of the right tonsil was occupied by sloughy-looking material. The edge of the left anterior pillar remained fairly normal; but in the left anterior pillar was a large oval perforation; the edge of the perforation was clean cut. The position of the left tonsil was occupied by sloughy material. There was slight ulceration of both posterior pillars. The ulcerative process had extended downwards, involving the base of the epiglottis (which was swollen); there was very superficial ulceration of mucous membrane of larynx; no deep ulceration and no perforation to be found.

There was extensive emphysema of the whole of the front of the neck, from the chin to the sternum and clavicles, etc., as had been observed during life. It also extended into the tissues behind the pharynx and into the anterior mediastinum.

I could not quite explain the emphysema—there was no emphysema or rupture of lung. Can the efforts of inspiratory dyspnœa, such as this child suffered from, draw air into the cellular tissues of the neck when these are opened by ulceration?

Beyond a little lobular pneumonia and pleurisy there was no other lesion anywhere.

Pass List.

University of Cambridge, June, 1894.

AT a Congregation held on the 14th June, the following Degrees were conferred:—

DOCTOR IN MEDICINE.

Samways, Daniel West.
Sutton, Charles Robert Arnold.

University of Oxford, June, 1894.

FINAL EXAMINATION FOR THE DEGREES OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY.

Munro, H. A.

Treasurer's Gold Medals.

SURGERY.

1. Enumerate the diseases of the tonsils, and give their differential diagnosis and treatment.

2. Describe the pathological changes which may follow the inoculation of the bacillus anthracis into the skin. Give the symptoms and diagnosis of such a case, and discuss the treatment.

3. Give the causes, diagnosis, and treatment of prolapsus recti, both in the child and the adult.

4. Enumerate the various forms of syphilitic disease of the joints; mention the diseases with which they may be confounded, and give the indications upon which you would rely in your diagnosis of each form.

MEDICINE.

1. Under what conditions may empyema arise? From what other lesions would you have to distinguish it? If left to itself, what are the usual and the occasional results; and what prognosis would you give if proper treatment is adopted?

2. Give the history and symptoms of the common form of tubal nephritis as you have seen it in the wards. What is your idea of its pathology, having special regard to the accepted division of tubal nephritis into acute and chronic? Upon what points would you rely for making a prognosis in such a case as regards both the ultimate issue of recovery or death, and the duration of the disease in its progress towards either?

3. In a case of motor paraplegia occurring within twenty-four hours in a strong and healthy young countryman, what symptoms would you look for to determine your diagnosis; and how would the prognosis and general line of treatment follow your conclusion?

4. How many varieties of systolic and diastolic murmur at the apex of the heart have you met with? In what respects has each differed from the others as far as you can describe them; and under what circumstances do you suppose each to have originated?

CASE FOR COMMENTARY IN SURGERY.

A GIRL, æt. nine, was the only child of apparently healthy parents, and sought advice on account of a large swelling of the upper and back part of the right forearm, which had been for some months gradually increasing in size. At the age of three she suffered from some affection of the right knee-joint, which resulted in fibrous ankylosis at a right-angle, and fixation of the patella to the front of the femur. From that time she had walked with the aid of a crutch, and the mother attributed the swelling to frequent falls upon the arm which carried the crutch. There was no history of infantile eruption, and her teeth were not notched. Mercurial treatment was tried without reducing the size of

the tumour. The knee-joint was neither swollen nor painful.

An exploratory incision was made over the back of the forearm, and a white fibrinous-looking material was observed to extend from the bone towards the skin. After consultation, it was deemed advisable to amputate this apparently useless limb, and it was noted that the supra-condyloid gland was somewhat enlarged, though the axillary glands were quite free.

The lower extremity was straightened, and she left the Hospital able to walk without artificial aid.

Two years later she suffered from an affection of the eyes, which was cured by treatment.

Her mother had never suffered from ill-health or from any skin affection, but she had been twice married, and the eldest surviving child of the first marriage, at the time aged eighteen, was very deaf and almost blind.

Comment on the probable pathology of this case, and describe any operation you may suppose was performed upon the knee affected.

CASE FOR COMMENTARY IN MEDICINE.

A WELL-BUILT, powerful man, aged sixty, enjoying habitual good health and active country pursuits, has, during the last few weeks, been troubled by frequent giddiness, most often on first rising, but the last attack was while walking home from a few hours' shooting. Florid complexion (white hair), five feet eleven, and fourteen stone. There is no headache, no loss of consciousness, and the stomach and bowels appear to be unaffected. The heart and pulse was normal and also the urine.

There is no anæmia nor loss of flesh. The patient has never been intemperate and never suffered from venereal disorder.

Blue pill and purgatives were ordered.

On a second consultation, five days later, it was elicited that he twice had suffered from acute pneumonia, and seventeen years ago had an attack of either syncope or eclampsia.

He now complained of fulness and tightness of the head, with occasional severe headache, frontal or occipital. He walked well and steadily, even with the eyes shut. The pupils react normal, and the fundus is normal. The cardiac sounds are clear but rather weak, the pulse regular and the urine normal.

Discuss the diagnosis, prognosis and treatment in order, mentioning particularly what subsequent symptoms you would look for to decide the diagnosis, and their bearing on the probable cause and the treatment.

Acknowledgments.

"Diseases of the Nose and Throat." F. de Havilland Hall, M.D. (London, H. K. Lewis.) 10s. 6d.

The Cambridge Review.

The Hospital.

St. Bartholomew's Hospital Journal.

Royal College of Surgeons of England.

THE following Examiners have been appointed for the ensuing collegiate year:—

FIRST CONJOINT.

1. *Elementary Anatomy.*—Messrs. L. A. Dunn (Guy's), W. H. H. Jessop (Bart.'s), J. E. Lane (St. Mary's), H. F. Waterhouse (Charing Cross).

2. *Elementary Physiology.*—Dr. J. R. Bradford (Univ. Coll.), Dr. H. L. Jones (Bart.'s).

3. *Elementary Biology.*—Mr. H. P. Dean (London), Dr. J. W. Shore (Bart.'s), Mr. F. G. Parsons (St. Thomas's), Mr. P. C. Mitchell (Charing Cross).

SECOND CONJOINT.

1. *Anatomy.*—Messrs. R. C. Lucas (Guy's), G. H. Makins (St. Thomas's), W. J. Walsham (Bart.'s), A. H. Young (Owen's), Dr. H. D. Rolleston (St. George's), Mr. C. Stonham (Westminster).

2. *Physiology.*—Messrs. W. D. Halliburton (King's), D'Arcy Power (Bart.'s), W. G. Spencer (Westminster), E. A. Schäfer (Univ. Coll.), Dr. T. Oliver (Newcastle), Dr. F. W. Mott (Charing Cross).

THIRD CONJOINT.

1. *Midwifery.*—Drs. W. Duncan (Middlesex), M. Handfield-Jones (St. Mary's), G. E. Herman (London), A. J. McRouth (Charing Cross), J. Williams (Univ. Coll.), T. C. Hayes (King's), J. W. Black (Charing Cross), W. S. A. Griffith (Bart.'s), W. R. Dakin (St. George's).

DIPLOMA IN PUBLIC HEALTH.

Part I.—Mr. George Turner (Guy's), Dr. A. P. Luff.

Part II.—Sir George Buchanan, Dr. E. C. Seaton.

TO THE COURT OF EXAMINERS.

Mr. Henry Morris (Middlesex).

FIRST FELLOWSHIP EXAMINATION.

1. *Anatomy.*—Messrs. W. Anderson (St. Thomas's), W. F. Haslam (Birmingham), W. H. A. Jacobson (Guy's), C. B. Lockwood (Bart.'s).

2. *Physiology.*—Messrs. J. Barlow (Glasgow), C. H. Golding-Bird (Guy's), B. T. Lowne (Middlesex), W. Stirling (Owen's).

Dental Appointments.

THE following Dental Appointments have been recommended by the Dental Committee and approved by the Treasurer:—

Dental House-Surgeons.—Messrs. F. C. Constant, P. F. Henry.

Assistant Dental House-Surgeons.—Messrs. U. E. Cave, T. R. Chambers.

Demonstrators in Conservation Room.—Messrs. A. Cahill, C. A. H. Keall, E. W. Stabb-Johnson.

From the Gazette's Special Pathologist.

ALL specimens, particularly those of solid tissues, should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra amount of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps which have been sterilised by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s.

Label all specimens *Immediate* and address to:—THE GAZETTE PATHOLOGIST, Guy's Hospital, London, S.E.

Postal Orders to be made payable to Mr. C. H. WELLS.

H., REIGATE.—No tubercle bacilli found.

G. F. H., BALHAM.—Tubercle bacilli present.

G. S. W., MELTON MOWBRAY.—Tubercle bacilli present.

W. E., CARDIFF.—Tubercle bacilli present.

G. R., BATTLE.—Tubercle bacilli present.

H. H., NORTHAMPTON.—Kindly send some details of the clinical history of case.

J. S. S., TAVISTOCK.—Spindle-celled sarcoma.

"A GUY'S MAN."—We should be pleased to receive information concerning the history and characters of growth.

G. H. M., CLARE.—No tubercle bacilli found.

J. C. W., ASHFORD.—No tubercle bacilli recognised.

W. B., STREATHAM HILL.—No tubercle bacilli recognised.

F. H. K., HUDDERSFIELD.—Many thanks for report. The tumour sent consists of columns of epithelial cells, surrounded by a well-developed ensheathing membrane of flattened cells two layers in thickness. These columns are connected by scanty vascular connective tissue of recent growth. The growing edge was not sent, so the question of infiltration is at present undecided. Can you forward the rest of the tumour?

PATHOLOGIST.

Notices.

STUDENTS' MICROSCOPES.

Messrs. Ross & Co., of New Bond Street, have lately brought out some new microscopes for the use of students. The form which we have inspected is that known as the "Eclipse," with inclining stand.

The stand is made of brass, and is very well finished and balanced. The instrument is fitted with a rack and pinion coarse adjustment, and both it and the fine adjustment work well and smoothly.

The stand is arranged to allow of inclination to the horizontal position, and in order to keep the microscope steady, the base of the stand can be reversed on the pillar. This is designed especially for micro-photography, and appears to be very satisfactory.

With the objectives, two-thirds and one-sixth of an inch, the definition and penetration are good.

The instrument with the above two objectives, two eye-pieces and double nose-piece, costs £8. If a rigid stand be chosen instead of the above, the price would be £6 15s. The case in which the microscopes are packed, is the handiest form we know of.

CASCARA JELLY (Horse-shoe Brand).

The Ext. Cascaræ Sag. Liquid. (P.B.), although an efficient preparation, is by no means an agreeable one. In Mist. Cascaræ Sagradæ (Guy's), an endeavour has been made to cover the exceedingly unpleasant bitter taste of the extract by means of liquorice, but in spite of this addition the mixture is very far from being pleasant.

Messrs. C. R. Harker, Stagg & Morgan, 15, Laurence Pountney Lane, London, E.C., have overcome the difficulty of covering the taste of cascara sagrada by the use of flavouring agents alone. They prepare a tempting-looking aromatic jelly containing cascara extract, which certainly can be readily taken by the most fastidious patient without the slightest difficulty.

It is well known that the bitter taste of the Cascara Bark can be removed by treatment with certain chemicals, but the activity of the extract is considerably impaired. The manufacturers specially state that the extract contained in the jelly has not been subjected to any chemical process, and that the absence of the bitter nauseous taste *is due solely to the peculiar combination of aromatics* employed.

We have given this Cascara Jelly a trial, and can say that it is a decidedly active preparation.

Appointments.

ELLIOTT, CHARLES CALDWELL, M.D., B.S.Lond., M.R.C.S., L.R.C.P., has been appointed Assistant Medical Officer to the New Somerset Hospital, Cape Town.

MARCH, E. GERALD, L.R.C.P. Lond., M.R.C.S. Eng., has been appointed House-Physician to the Hospital for Consumption and Diseases of the Throat and Chest, Manchester.

MILLS, THOMAS INGHAM, L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Third House-Surgeon to the Infirmary, Huddersfield.

SHEEN, A. W., M.B., B.S., M.R.C.S., L.R.C.P., has been appointed Senior Resident Medical Officer to the Glamorganshire and Monmouthshire Infirmary, Cardiff.

TODD-WHITE, A. T., M.R.C.S., L.R.C.P. Lond., L.S.A., has been appointed House-Surgeon to the Infirmary, Lancaster.

Sport.

Cricket.

GUY'S v. ASHTON GRAMMAR SCHOOL, DUNSTABLE (MASTERS AND BOYS XI.)

Played at Dunstable on Saturday, 9th June. We won the toss and went in to bat on a dead slow wicket. Francis played very well for his 25, and Nicholls hit hard with some good fortune; the rest did very little, and the total only reached 69. During and after lunch, the rain came down as if it had never done such a thing before, and when it became possible to resume, the wicket was very easy for batsmen, and very bad for bowlers. Thring hit very well indeed, and his 83 included thirteen 4's; he had some luck, but only gave one moderately easy chance. Except Healing, the rest did not advance the score much, but we were easily beaten by 95 runs. Sharp took four wickets for 24 runs, Shorland three for 38. We were most hospitably entertained by Mr. Thring, both at lunch and dinner, and our best thanks are due to him for his kindness. Score:—

GUY'S

C. J. Francis, st Sanger, b Brown	25
N. H. Pike, run out	7
E. T. Shorland, c and b Thring	0
R. B. Stamford, b Thring	0
F. J. Nicholls, c Ryder, b Brown	19
P. C. Prince, b Thring	4
K. B. Alexander, run out	0
H. C. Sharp, not out	6
H. Hewetson, c Stephenson, b Thring	0
E. G. Blow (sub), b Thring	0
E. D. Hancock, c Thring, b Brown	3
Extras	5
Total	69

DUNSTABLE G. S.

L. C. R. Thring, b Shorland	83
J. T. Phillipson, c Hewetson, b Nicholls	13
J. Manton, c Alexander, b Pike	3
R. Ryder, c Hewetson, b Pike	0
J. Healing, c and b Shorland	27
W. F. Brown, b Shorland	0
J. Sanger, c Nicholls, b Sharp	6
S. G. Stephenson, b Sharp	3
R. Hornby, c Alexander, b Sharp	2
W. Preston, not out	7
C. M. M. Cameron, c Hewetson, b Sharp	0
Extras	14
Total	158

GUY'S v. CHARING CROSS.

CUP TIE.

Played at Honor Oak Park on Tuesday, 12th June, and won easily by Guy's by ten wickets. Charing Cross batted first, but could not do much against the bowling of Hancock—six for 20, and Shorland—four for 29. The first wicket produced 25 runs, but after that no one did anything, and the total only reached 62. For Guy's, Perks, Hancock and Nicholls did well, but the two former threw away their wickets rather foolishly. Young's five wickets cost 53 runs, but the rest of the bowling was not startling. The second innings of Charing Cross was a repetition of the first, only one man reaching double figures. Shorland took seven wickets for 26 runs, Nicholls two for 11, and Hancock one for 18. Their two innings just equalled our one, so Alexander and Fitzhugh went in, and Alexander hit a 4 in the first over, which gave us the victory as above stated. Score:—

CHARING CROSS.

	1ST INNINGS.		2ND INNINGS.	
W. S. Colyer, c Hancock, b Shorland	17	b Shorland	0
P. Philips, c Pike, b Shorland	7	Not out	2
N. J. Roche, c & b Hancock	6	c Perks, b Nicholls	26
F. Forsyth, b Shorland	7	b Nicholls	2
J. H. C. Fegan, b Hancock	0	b Shorland	3
N. P. King, c Francis, b Shorland	5	b Shorland	2
E. C. Montgomery, b Hancock	3	b Hancock	7
C. W. Young, b Hancock	3	b Shorland	2
W. Wilkins, not out	0	lbw b Shorland	3
G. S. Jones, b Hancock	0	b Shorland	8
L. N. Lloydd, b Hancock	0	b Shorland	0
Extras	13	Extras	8
Total	62	Total	63

GUY'S.

	1ST INNINGS.		2ND INNINGS.	
C. J. Francis, b Young	3			
A. Perks, run out	22			
W. I. Hancock, run out	18			
R. B. Stamford, b Lloydd	11			
F. J. Nicholls, not out	32			
E. T. Shorland, b Young	8			
N. H. Pike, b Colyer	1			
K. B. Alexander, b Young	1	not out	4	
R. T. Fitzhugh, c Roche, b Young	6	not out	0	
P. C. Prince, c Forsyth, b Young	3			
H. Simson, b Lloydd	3			
Extras	17			
Total	125	Total	4	

GUY'S v. STREATHAM.

Played at Honor Oak Park on Saturday, 16th June. Francis won the toss and commenced batting with Perks, and the pair scored 74 for the first wicket. The next three wickets added 63, and then Shorland came along, and at once began to lay about him; the score rose at a tremendous pace, and the fifth wicket realised 87 runs, of which Shorland had 57, including eight fours and only three singles. Pike and Perks put on 29 for the sixth wicket, and then at last Perks was out, having played excellent cricket for his 86. The closure was then applied.

In their innings, Mortimer and Miller, the first pair, looked like giving some trouble, but Miller cut a ball from Hancock into his wicket, and Mortimer was caught at short slip, and no one else did much, except George, who batted very well for his 34. Nicholls bowled with great effect in the latter part of the innings, securing four wickets for 12 runs, Shorland had three for 46, Hancock two for 34.

So far we have won all the matches played at Honor Oak Park; if this is kept up, our record may not be quite so bad as looked at one time likely. Score:—

GUY'S.

C. J. Francis, c Kerr, b Mortimer	38
A. Perks, b Tomkins	86
W. I. Hancock, c Tomkins, b George	15
R. B. Stamford, b George	15
F. J. Nicholls, b George	10
E. T. Shorland, c Roberts, b Wilson	57
N. H. Pike, not out	18
K. B. Alexander, did not bat	
H. C. Sharp, did not bat	
W. Palmer, did not bat	
F. H. Loud, did not bat	
Extras	14
Total (for 6 wickets)...	253

STREATHAM.

L. Mortimer, c Nicholls, b Hancock	25
H. Miller, b Hancock	14
H. W. Wilson, run out	13
W. H. Greathead, c Stamford, b Shorland	3
A. George, b Nicholls	34
A. C. Roberts, lbw, b Nicholls	6
S. Steel, b Shorland	6
D. O. Kerr, b Nicholls	1
C. Tomkins, lbw, b Shorland	3
E. P. Pulbrook, c and b Nicholls	0
J. Hardy, not out	1
Extras	19
Total	125

Guy's Hospital Athletic Sports.

These Sports were held on the London Athletic Club Grounds, Stamford Bridge, on Thursday afternoon, in fine weather, and in the presence of a large company. Mr. F. W. Parker was starter and handicapper for open events; C. Higgens, Esq., F.R.C.S., J. H. Bryant, Esq., M.D., and J. Fawcett, Esq., M.D., F.R.C.S., judges; and Nat Perry, timekeeper.

Though the fields were not as large as might have been expected from the number of entries on the programme, the racing was excellent in many of the events. Batchelor, who ran with great judgment, accomplished first-rate performances in both the half and quarter-mile events, the times for which were 2 minutes, 4⅖ seconds, and 51⅖ seconds respectively. The latter must almost be a record for our own sports. East won both the hundred and two hundred-and-twenty yards, and ran in a taking and pretty fashion. Lowe was in good form at the hurdles, and having to concede 20 yards start, won with a yard in hand from Higgens, in 20 seconds. Neither Bell nor Munro were able to turn out, the former suffering with a slightly strained leg, and the latter taking a well-earned rest after his success in the University of Oxford Final M.B., B.S. examinations. The mile, accomplished in the remarkably fast time of 4 minutes, 27⅕ seconds, was won by Pike from the limit mark; the three miles by Crew, also the limit man.

In the field events, Scott obtained the "shot with a put of 33 feet 1 inch, and threw 82 feet 4 inches in the "hammer" event, which was won by Palmer, to whom 20 feet was conceded by the scratch man. Palmer also secured the high jump, Lowe (owes 5 inches) failing above 5 feet 3 inches, a height a good deal less than it *looked*. The Strangers' race produced some fine running, and Bredin had hard luck in not winning, his time being 1 minute 57⅕ seconds. In the long jump, Collier performed very creditably, his best effort being 20 feet 1 inch.

During the afternoon, a tornado (?) was responsible for some damage. In the midst of delightful summer heat, and while the band was discoursing sweet strains, the wind, wishing no doubt to play a tune on its own account, swept down upon the unlucky performers in a perfect whirlwind, but failing to produce any effect upon the cornet, trombone, bassoon, or any of the *wind* instruments, wreaked its revenge elsewhere. Catching up the musical score and manuscript before the astonished bandsmen could move a finger in protest, this diverting little "doldrum puff" whirled the heavy books veritably like chaff, round and round, through a diameter of about thirty yards! It was a sight not to be missed, and never to be forgotten. Music, sunshades, top-hats, dust, careering madly round and round; "and the band"—— stopped playing. Here was an opportunity for budding poets; a beautiful opportunity—never such another in a lifetime—for a parody on "The Lost Chord."

100 YARDS HANDICAP.—Heat 1: G. R. Edey, 7 yards start, 1; H. J. Spon, 6, 2. Time, 10⅖ sec. Heat 2: W. N. East, 10, 1; T. M. Walker, 8, 2. Time, 10½ sec. Heat 3: E. A. Longhurst, 6, 1; G. H. Bignold, 6, 2. Time, 10⅘ sec. Heat 4: H. N. Collier, 6, w.o. Heat 5: J. Moore, 8, w.o. Heat 6: C. E. Hibbard, 9, 1; H. W. Dudgeon, 10, 2. Time, 10⅖ sec. Final Heat: East, 1; Collier, 2; Longhurst, 3. Won by a yard and a half; a yard more between second and third men. Time, 10⅖ sec.

HALF-MILE HANDICAP.—F. S. Batchelor, scratch, 1; R. Balderson, 35 yards start, 2; C. B. Dowsett, 40, 3. Won by six yards; a dozen separating second and third. Time, 2 min. 4⅖ sec.

THREE MILES BICYCLE HANDICAP.—C. Reed, 300 yards start, 1; H. J. M. Smith, 150, 2; Austin Wood, scratch, 3. Won by two hundred yards. Time, 8 min. 37⅕ sec.

120 YARDS HURDLE HANDICAP.—Heat 1: P. R. Lowe, owes 20 yards, 1; E. B. Dowsett, scratch, 2. Won easily. Time, 21⅖ sec. Heat 2: H. A. Higgins, scratch, 1; E. Grace, owes 10, 2; F. P. Palmer, owes 10, 3. An easy win. Time, 20⅗ sec. Final heat: Lowe 1; Higgins, 2; Grace, 3. Won by a yard. Time, 20 sec.

ONE MILE HANDICAP.—N. H. Pike, 210 yards start, 1; A. E. Maturin, 130, 2; C. D. Edwards, 80, 3. Won by sixty yards. Time, 4 min. 27⅕ sec.

220 YARDS HANDICAP.—W. N. East, 14 yards start, †1; T. M. Walker, 14, †2; H. N. Collier, 10, 3. Won after a dead heat by a yard and a half. Time, 22⅘ sec.

THROWING THE HAMMER (HANDICAP).—F. P. Palmer, scratch, 69ft. 7in. 1.; E. N. Scott, owes 20ft., 82ft. 5in. 2.

440 YARDS HANDICAP.—F. S. Batchelor, scratch, 1; E. A. Longhurst, 10 yards start, 2; H. Bignold, 20, 3. Won by two yards; a moderate third. Time, 51⅖ sec.

HIGH JUMP (HANDICAP)—F. P. Palmer, scratch, 4ft. 10¾in., 1; P. R. Low, owes 5in., 5ft. 3in., 2.

660 YARDS VETERANS' HANDICAP (open to men over their fourth year).—P. Purnell, 30 yards start, 1; H. J. Spon, 35, 2; N. Instone, 10, 3. Won by three yards. Time, 1 min. 22⅗ sec.

880 YARDS STRANGERS' HANDICAP.—F. J. Gaine, St. Mary's Hospital, 90 yards start, 1; G. F. Crisp, L.A.C., 135, 2; E. Bredin, L.A.C., scratch, 3; E. J. Wilkins, 25, 0; A. R. Williams, 27, 0; A. R. McCullough, 40, 0; J. W. Palmer, Blackheath, H., 48, 0; P. G. Mould, L.A.C., 50, 0; L. S. Gaskell, London Hospital, 55, 0; G. E. Mould, L.A.C., 115, 0; G. R. Elvin, St. Mary's, 75, 0. A good race, Gaine winning by three yards. Bredin about seven behind the second man. Time, 1 min. 55½ sec. Bredin ran his first quarter in 54½ sec., and the full distance in 1 min. 57⅗ sec.

PUTTING THE SHOT.—E. N. Scott, owes 2ft., 32ft. 7in., 1; W. D. Macdonald, owes 1ft., 31ft. 5in., 2.

LONG JUMP HANDICAP.—H. N. Collier, owes 1ft., 19ft. 6in., 1; P. R. Lowe, owes 1ft., 18ft. 5in.; 2.

THREE MILES HANDICAP.—C. T. Crew, 2 min. 20 sec start, 1; F. N. Henry, 2 min. 2; C. D. Edwards, 40 sec. 3. Won by ninety yards. Time 18 min. 35 sec.

SACK RACE.—R. T. Brown, 1; B. Brown, 2.

At the close of the Sports, the prizes were graciously distributed by Mrs. Pye-Smith, a vote of thanks to whom was proposed by Mr. Lucas, and carried with acclamation. The company then dispersed to the strains of the National Anthem, having apparently thoroughly enjoyed the afternoon's sport, not to speak of the typhoon.

Sporting Notes.

ATHLETICS.

With regard to our prospects in the coming United Hospitals Championship Meeting, we should still be able to retain the shield. Bell, Munro, Lowe, Batchelor, and Scott will, we suppose, represent us as first strings in their respective events, while of the others, Longhurst, who shows improvement on last year's form, Collier, Palmer, Edwards, and East, were the best on Thursday last. With Bell quite strong again, we can hope for a repetition of his previous successes, though it is early yet to make predictions. As far as has been ascertained from the accounts of other Hospital Sports, no startling performances are as yet to hand. Both Batchelor and Munro are credited with the best performances, and Lowe also in the Hurdles has not been approached. Scott has up to the present shown uncertain form; he has to fear Mackintosh in both Putting the Shot and Throwing the Hammer.

CRICKET.

The eleven are to be congratulated on their substantial defeat of Charing Cross in the Cup Ties. That they are returning to proper form is evidenced by the defeat of Streatham—generally a hard nut to crack—on Saturday last. Our chief scorers were Perks, who compiled 86 by excellent cricket, and Shorland, who was responsible for a freely hit innings of 57.

The Cup Ties are going on apace, and we shall soon have the end before us. In the second round, besides our own victory, Middlesex easily disposed of University College, while St. Thomas's gained a most decisive win against Westminster without the loss of a wicket. St. Bartholomew's who, from all accounts are a strong lot, met and defeated St. Mary's after a good game.

So far all the matches have been played on the Clubs' Union ground at Honor Oak, and although there have not been large gates, every satisfaction has been expressed at the arrangements and condition of the ground, which have been ably carried out by Harris and his assistants.

TENNIS.

We have again to regret the defeat of the six in the Cup Ties at the hands of the holders, St. Thomas's. We are assured that the latter were the better team, four of whom are among the front rank of tennis players. Guy's were without the services of Clarke and Stoker, or a different result might have been expected.

SWIMMING.

Members are reminded that the annual subscription of 2s. 6d. to the Swimming Club is now due. After the enthusiasm shown at the General Meeting the Club ought to do well during the season, especially in regard to polo, practise for which should be diligently indulged in. It has been decided to adopt the Camberwell Baths as head-quarters, when all necessary arrangements are completed, an affair which, it is to be hoped, will speedily be carried out.

Guy's Hospital Rifle Association.

THE first Prize Competition was held at Ilford, on June 12th, when eleven men made their appearance at the range. Shooting was poor, especially at 500, where a peculiar mist appeared and affected elevation to an extraordinary degree, several men being from four to seven degrees above normal. At 600 the handicapping began to tell, and seven men were well in the running. Jenkins was doing well, but had his rounds to fire at 200, having arrived late. Telling shot up, with an excellent twenty-nine, and eventually after a most exciting shoot, tied with Ashwin, but under the U.H. rules, gained the tie on the score at the longest distance. When all had finished, Jenkins wanted twenty-one to win, and with this easy little job, went cheerfully back to 200. There, amidst enthusiasm which was greatly detrimental to the shooting of the "Devil's Own," he compiled twenty-four, thus winning by three points. Telling being second, and Ashwin third. Scores:—

	200	500	600	Hp.	Aggregate.
C. C. Jenkins ...	24	26	23	10	83
W. H. Telling ...	23	18	29	10	80
R. H. Ashwin ...	30	16	24	10	80
H. Fulham-Turner ...	24	17	27	10	78
A. Scott-Turner ...	23	14	20	20	77
W. B. Secretan ...	25	14	20	15	74
J. E. Dupigny ...	23	12	7	30	72
J. E. Holman ...	27	8	6	30	71
A. J. Collis ...	21	10	2	25	58
S. H. Mason ...	21	0	9	25	55
G. Bedford ...	9	2	2	30	43

GUY'S v. WHITGIFT.

This match was shot on Monday, June 18th, at Marden Park, at the ranges of 200 and 500 yards. The duties of H.-S. unfortunately prevented our captain from shooting, and one man, at the last moment, thought he would prefer an arm-chair in the smoking-room to taking his place in the team, and consequently we were one man short.

We were landed at Woldingham station at 5 p.m. in a drenching rain, and when we arrived at the range we found the Whitgift boys just finishing their shoot at 500 yards. They were shooting extremely well, their first seven making a score of 176, the best individual scores being Brodie 30, and Malden 31. We then started shooting at 200 yards; at that range the scores were about average, except that Secretan put on a very good 30. Of the first four down at the long range, Scott-Turner scored 29 in his best style, while Ashwin made himself equally conspicuous by a consistent string of misses. But it was not until Fulham-Turner went down that the fun began, someone having introduced a live shrew into his trouser-leg; the mouse was quite equal to the occasion and located itself in the left inguinal region, where it remained some time while the gentleman in question danced a *pas de seul;* the band playing appropriate music. After a long and painful (to the mouse) labour, the living animal was delivered, forceps not being required. In spite of this slight disturbance the worthy "warrior" scored an excellent 30. The final result was that we were beaten by 61 points. Scores:—

GUY'S.	200	500	Aggregate.
Scott-Turner ...	26	29	55
Robinson ...	19	16	35
Telling	26	19	45
Ashwin	27	8	35
Holman	24	14	38
Secretan	30	18	48
Fulham-Turner ...	22	30	52
			308

WHITGIFT.			
Brodie	28	27	55
Hampton	30	24	54
Brodie	30	30	60
Reed	27	29	56
Malden	29	31	60
Symondson ...	28	19	47
Hampton... ...	21	16	37
			369

Births.

DENMAN.—On June 5th, at Ellel House, Bournemouth, the residence of her mother, the wife of Robert Denman, Surgeon, of a son.

RICKETTS.—On May 30th, at Greenhithe, Kent, the wife of Dr. T. F. Ricketts, of a son.

WALLIS.—On June 5th, at East Grinstead, the wife of P. E. Wallis, L.R.C.P., M.R.C.S., of a son.

Marriages.

BATES—SCOTT.—June 2nd, at St. Stephen's, South Dulwich, by the Rev. G. C. Bellewes, Vicar of Bishop's Taunton, North Devon, assisted by the Rev. F. E. White, Vicar of the Parish, James Curling, youngest son of the late Jonah Bates, H.M. Customs, to May Emmeline, youngest daughter of the late Patrick Scott, H.E.I.C.S., of Glendon, Dulwich Wood Park.

LUMLEY—BALL.—On June 23rd, at St. Augustine's, Honor Oak, Frederick Davidson Lumley, Surgeon, R.N., younger son of Thomas Lumley, Fleet Engineer, R.N. (retired), to Pattie Codrington, younger daughter of the late Staff Commander Edward Codrington Ball, R.N., K.L.H.

TRESIDDER—JAMES.—On the 19th inst., at Bottesford Parish Church, by the Rev. H. H. Wood, assisted by the Rev. E. H. Stone, William Elliott Tresidder, M.B. Lond., of Sherwood Street, Nottingham, fourth son of the late Surgeon-General Tresidder of H.M. Indian Medical Service, to Gertrude, younger daughter of William James, of Bottesford.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE

Guy's Hospital Gazette,

JULY 7, 1894.

Acquired Deformities.

CLINICAL LECTURE BY MR. ARBUTHNOT LANE.

GENTLEMEN,—I would urge on you very strongly when you are studying clinically the several surgical conditions with which you must render yourselves familiar, not to be satisfied with accepting the usual text-book statements of their causation, unless, on applying to them the test of your sound common sense, you find that they are perfectly intelligible and rational.

You may, I think, conclude that any explanation of the causation of a condition that, after thoughtful consideration, appears confused, complicated and verbose, is probably false.

When a writer has in his own mind no definite idea of the cause of a morbid condition, he often takes great pains to render his description of it as unintelligible and vague as possible, or he smothers the reader with a number of views held by various authors, each usually utterly at variance with the other.

General laws are, as a rule, very simple, readily intelligible and capable of proof, and the importance of a principle is generally directly proportional in degree to its simplicity.

I would, therefore, advise you to avoid, as much as the examination demon will permit you, assimilating in an unchanged form the accumulation of what passes for knowledge, unless you have first digested it, absorbing the reasonable, and excreting anything which cannot bear the closest criticism.

I intend in this lecture, to attempt to explain the anatomy and the causation of the several acquired deformities which are painfully familiar to us in the out-patient room, and which too frequently derive very little benefit from our treatment of them, for the reason that we are unable to place our patients under such circumstances as would bring about their recovery.

The deformities I allude to are knock-knee, flat-foot, lateral curvature and dorsal excurvation. These I will call for convenience "resting" deformities, the reason for which I will show later.

It is obvious that if you are unfamiliar with the anatomy, physiology and causation of these conditions, you are not in a good position to treat them. You are still more unfortunately placed if the idea you have of the mode of their production, etc., is absolutely false. There is, perhaps, no branch of surgery about which so many various theories of causation have been evolved, and about which so much obscurity and ignorance exists even in the best standard works on surgery.

One is very liable to imagine from a knowledge of anatomy as taught by the text-books, that the construction of the human body does not allow of much variation. A little careful study will, however, show you that not only do the forms of the bones of the human adult skeleton vary with such movements as are performed habitually, and with such routine attitudes as are assumed by the vigorous individual, but also do the details of the structure and the functions of the several joints.

If an individual is habitually engaged in performing a certain movement or sequence of movements of activity, the form of the skeleton varies from the normal in a degree which is proportionate to the length of the period during which the movement has been performed, and to the amount of energy expended in the act. During a single performance of the attitude of activity there are present numerous tendencies for the bones and joints to undergo changes in form. Their constant repetition enables the tendencies to become actualities. The earliest variation from the normal consists in the fixation of the physiological attitude which is normally assumed during the performance of such a movement of activity, while the latter changes are exaggerations of the same attitude due to changes in the bones and in the intervening soft structures. In other words, *the peculiar character of the anatomy of the labourer is, first, the fixation, and subsequently the exaggeration of a normal physiological attitude of activity.*

A workman who for a large number of years has followed the same laborious occupation, possesses an

anatomy which is unmistakably characteristic of that occupation, and which in many cases differs from what we are accustomed to regard as the normal anatomy of the human subject, infinitely more than the latter differs from that of the ape.

The variations exist not only in the separate bones and joints, but in the arrangement of these bones.

Compare, for instance, the clavicle and scapula of the shoemaker with those of the sailor and deal porter, and the least observant will see at once the very great difference in the form of the several bones. A little consideration of the peculiar physiology of each occupation will show you the factors that have produced the characteristic form of each bone. They are chiefly ossification of muscles along the lines of habitual traction, and the alteration in form which results from the habitual transmission of considerable force in certain directions. Another important factor, though perhaps a less obvious one, is the formation of a new bony structure, with a view to the better transmission of force under any mechanical circumstances peculiar to the occupation or acquired physiology of the individual. This is shown very well in the atlas of the man whose function it has been during a long lifetime to sew boots. In this individual, the obliquely-placed head is supported on a column of bone which grows upwards from the lateral mass of the atlas, and forms for itself an articulation with the under surface of the jugular process of the occipital bone. If you wish to pursue the subject further, you will find the anatomy and physiology of the shoemaker fully described in the *Journal of Anatomy and Physiology*, July, 1888.

Then examine the spine of the coal trimmer, whose anatomy and physiology is described in the same Journal of April, 1887, and you will find that, in consequence of the forcible rotation of the trunk upon the pelvis in throwing coal to places at a distance, the neural arch of the fourth lumbar vertebræ is completely divided, and an arthrodial joint is formed between the bodies of the fourth and fifth lumbar vertebræ, the fibro-cartilage which originally existed there having been more or less completely removed.

Again, observe the spinal column of this drayman, and see the large single lateral curve, with changes in the form of the several portions of the vertebræ in the intervening fibro-cartilages, and in arrangement of the vertebræ, ribs, etc.; or look at the spine of the coal-heaver, and notice the obliteration of the dorsal and lumbar curves, the removal of the amphioarthrodial joints between the lumbar vertebræ, with their more or less complete synostosis, together with the downward and forward displacement of the fifth lumbar vertebræ off the sacrum, a condition dignified by the name spondylolisthesis.

Many of the changes in the form of the ends of the bones and in the character of the joints had been previously observed by pathologists, and had been regarded as examples of a disease called rheumatoid arthritis, with which, of course, they have no causal connection or relation whatever, though they are in appearance somewhat similar.

The human skeleton retains what is regarded as its normal anatomy only as long as it is called upon to perform normal functions, and those not excessively.

I would now point out to you, that for the so-called normal condition of the skeleton, it is necessary during growing life that the individual shall combine attitudes of activity with attitudes of rest, and that the attitudes of activity, as well as those of rest, be varied in character. By an attitude of rest is meant a position in which the superjacent weight is transmitted through a joint, or joints, with a minimum of expenditure of muscular energy, the form of the bones and the ligaments sustaining the chief strain, the muscles in many cases performing only the passive function of a ligament.

As already explained, during the single assumption of an attitude of activity, there exists tendencies to change, both in the forms of the bones and of the joints, resulting in the alteration if the attitude be assumed habitually. So also during the period of a single assumption of an attitude of rest, there exists tendencies to change, both in the form of the bones and of the joints, resulting in the alteration if the attitude be constantly adopted. This occurs very much more readily and extensively in the growing subject, than in such as are fully developed, for the following reason, which I will state in the form of a general law, the importance of which you will readily perceive.

In the young subject, the rate of growth of any portion of an epiphysial line varies inversely as the amount of pressure it transmits. In other words, if one half of an epiphysial line transmits habitually an amount of pressure which is greater than normal, the amount of bone which it developes is correspondingly less than that normally produced. If, on the contrary, the other half of the epiphysial line is subject habitually to a subnormal pressure, the amount of bone developed by it is proportionately greater than the normal. In all the resting postures, the mechanism of the skeleton is such that one portion of a growing line is exposed to an abnormal amount of pressure, while another portion is exposed to a much less or even subnormal amount of pressure. The

frequent assumption of a single attitude of rest, not corrected by suitable variations in the attitudes of activity and rest, results finally in a progressive alteration in the form and function of the bones and joints. The soft parts intervening between portions of bone which habitually transmit an abnormal amount of pressure, first become thinned and fibrous, and later may be completely removed. If the bones move freely upon one another, the exposed osseous surfaces become dense and eburnated, but if very little movement takes place, the opposing surfaces of bone may unite. It is obvious that when these changes have advanced to any extent, they cannot be obliterated by treatment, the original form of the skeleton being lost for ever. This law has a most important bearing on the evolution and treatment of acquired deformities.

One knows also that the more vigorous and robust the child, the less likely he is to assume attitudes of rest for any time; while the feeble-bodied and frail is but little disposed to expend his scanty muscular power in activity, but prefers to assume such easy postures as make as little demand as possible upon his store of energy, the particular variety of resting posture varying to some extent with the age, surroundings, and often also with the occupation of the individual.

If you accept as true the views which I have attempted to place before you, I will pass on to the consideration of the causation of knock-knee.

If the active erect posture be assumed, and a plumb line be dropped through the head of the femur, it will be seen to fall much outside the centre of the joint. If the easy erect posture be assumed, and the weight of the leg be supported upon one leg, the total weight of the body falls upon the knee-joint through a point in a transverse vertical plane, which is still more external to the centre of the joint. If this posture be habitually adopted, the outer portion of the growing lines of the femur and tibia form bone more slowly than normal, while their inner segments form it more rapidly. Consequently the internal condyle becomes longer, and the outer shorter than in the normal skeleton. As the external femoro-tibial angle diminishes, the patella is displaced further and further outwards, till finally it rests on the outer surface of the external condyle in the most advanced condition of knock-knee.

In such positions of activity as are occupied in running, you see that the plumb line falls very considerably internal to the knee-joint in a vertical transverse plane, during which period the several portions of the growing lines are exposed to conditions of pressure, the reverse of those existing in the resting posture.

Therefore, to remove this deformity by other means than operation, it is necessary to apply a mechanical contrivance which shall act in such a manner that the amount of pressure transmitted through the several portions of the growing line be reversed, and the consequent rate of bone formation altered till the normal form is obtained, while at the same time attempts are made to improve the patient's general nutrition, to make him avoid such attitudes of rest as were originally responsible for the development of the deformity, and to assume as constantly as possible attitudes of activity, and especially such as are antagonistic in their action to this particular attitude of rest. These same principles apply with equal truth to the treatment of the other resting deformities, and will therefore not be recapitulated.

Now we will pass on to the consideration of flat-foot. *The attitude of activity of the foot is one of considerable adduction, or, as it is sometimes called, inversion.* The arches are raised, and the inner margin of the foot forms with that of its fellow an angle which is open backwards. You can see this to perfection in a very fast runner, whose well-developed and highly-trained muscles retain his feet in a position of extreme activity. Watch such a man walk or run, and you see that he turns his toes inwards to a considerable extent, so that the slightly concave inner margins of his feet form an angle open backwards.

The position of rest of the foot is that of abduction, in which the arches are depressed while the inner margin of the foot is rendered convex, and forms with that of its fellow an angle of considerable size open forwards. *This position becoming fixed, and later exaggerated, is called flat-foot, which is, therefore, simply the fixation of the foot in its position of rest.* Adduction and abduction of the foot take place in the subastragaloid joint. It is taught in anatomical works that adduction and abduction take place to a considerable extent in the ankle-joint when in a position of flexion, but this I showed in a paper in the *Journal of Anatomy and Physiology*, April, 1888, to be absolutely false.

Movements of adduction and abduction of the foot take place entirely in the subastragaloid joint. The movement is not simply a rotation of the foot around the long axis of the astragalus, but in adduction it is associated with an elevation of the height of the arches of the foot, its inner margin being rendered distinctly concave, while in abduction the arches are depressed and the inner margin of the foot is rendered distinctly convex. To explain the causation of this, I must call your attention to a strong ligament which had escaped the attention of anatomists till I described it in a paper in

the Guy's Hospital Reports for 1886—1887, page 252. It is continuous with the inferior calcaneo scaphoid ligament with which its fibres run parallel. It is attached to the anterior portion of the sustentaculum tali, and from this its fibres run forwards, upwards and outwards, to be attached to the tuberosity of the upper margin of the scaphoid. This I called the superior internal calcaneo scaphoid ligament. You may remember that the tibialis posticus, immediately before its insertion, sends a process downwards and backwards to the sustentaculum tali; when the tibialis posticus contracts it by this double insertion, besides tending to pull both bones upwards tends also to approximate them.

In drawing up the tubercle of the scaphoid, it winds up the superior internal and inferior calcaneo scaphoid ligaments, approximating therefore the sustentaculum tali and scaphoid, and displacing the head of the astragalus outward upon the greater process of the os calcis, where, in labourers who are in the habit of carrying heavy loads, a new joint is developed, for obvious economical purposes.

The rotation of the os calcis results in a partial forcible separation of the opposing concavo-convex surfaces of the os calcis and cuboid, which, being opposed by the long and short ligaments, results in an elevation of the outer arch also.

In abduction, the sustentaculum tali and tuberosity being free from the strain exerted by the tendon of the tibialis posticus, fall apart, partly on account of the cessation of the traction exerted by the bifid tendon and partly because the consequent rotation of the scaphoid upon the astragalus is followed by an unwinding of the calcaneo scaphoid capsule, resulting in its *apparent lengthening*. This apparent lengthening has suggested the explanation of flat-foot which is usually given, namely, that it is due to yielding of the inferior calcaneo scaphoid ligament which is described as being an elastic structure. This is obviously absurd. The head of the astragalus occupies the increased interval between the tuberosity of the scaphoid and the sustentaculum tali, and the opposing surfaces of the cuboid and os calcis coming into accurate apposition the outer arch reaches its limit of depression.

When the foot is retained habitually in the attitude of rest, or of abduction, it becomes fixed in that position, the patient experiencing pain in that portion of the head of the astragalus which is only saved from direct pressure by the unwound calcaneo-scaphoid capsule, and is pain of the same character as that felt in hallux valgus, owing to abnormal pressure being exerted upon the articular surface of the head of the bone. Pain is also felt in the upper part of the calcaneo-cuboid joint owing to stress of opposing bony margins, and also later owing to the impaction of the external malleolus upon the os calcis. The fixation of the foot is, in early cases, due to the violent contraction of the abductor muscles which oppose the movement of adduction because it is painful, and in later cases adduction is opposed by changes in the form of the bone of joints of the nature of a mechanical arthritis.

Prize Day, 1894.

The distribution of prizes held last Wednesday, July 4th, went without a hitch. A very large number of visitors streamed into the Hospital after 2.30, the band of the Royal Engineers performing a selection of music in the tent until three o'clock, and later in the park. The Wards, Museums, Dental School Buildings, College, and Chapel were open for inspection, while the ever-welcome afternoon tea was provided in the College Hall, the Dental School Buildings, and in Addison ward. The beautiful weather was responsible, we suppose, for the many charming summer costumes worn by the ladies, making the scene in the tent and in the park a very animated one, while the excellent music of the Royal Engineers was greatly appreciated.

The sisters and nurses must have worked very hard to have done so much to beautify the wards in the time at their disposal, for they were brightened up with large bouquets of bright flowers. Some, more fortunate in securing large quantities of flowers, had gone in for extensive floral decorations. In Clinical, fronting the entrances to John and Miriam, were tables profusely covered with vases of roses, while each patient was provided with a small bouquet of cornflowers. Accident and Cornelius both looked well, the former somewhat darkened by the shade thrown from the great tent. Martha and Lazarus, contenting themselves with simple arrangements of roses, sweet-pea and foxglove, looked none the less effective. Job was quite one of the most elaborately-decorated of the wards. Here some tall tiger lilies had been arranged to some purpose, and the window-sills looked very pretty, if somewhat ecclesiastical. Large numbers of choice flowers were arranged in masses on tables down the ward, the prevailing tone being white, and producing a charming sight to the eye.

In Lydia, too, no pains had been spared with the quantities of flowers at the disposal of the decorators. We were struck with the very attractive arrangement of some wildflowers in two of the windows, the grasses

especially doing their duty well. Charity had fewer flowers, but made good use of them; here there was an arrangement of yellow poppies with blue cornflowers which gave a pretty result.

In Dorcas the prevailing tone was pink. Pink hydrangea, pink sweet-pea, and an elegant arrangement of pink ivy-geranium over a light-coloured screen in the fireplace made the ward very bright.

Naaman decorated itself chiefly with delicately-tinted sweet-pea and roses, as also did Samaritan and Patience. In Luke there was an artistic arrangement of variously-coloured poppies and sweet-pea, in masses of one colour. Set off by light fernery in some delicate vases, the whole effect was so charming as to make the ward feel cool and light. We were not surprised to find this ward admired as one of the best. In the Medical Wards, Mary had received careful attention, a judicious massing of yellow poppies and cornflowers appearing most effective.

In Philip, the flowers were tastefully arranged along the ward, while in Stephen equal care had been bestowed. Here there were some magnificent tiger lilies and some fine ferns.

THE DEAN'S REPORT FOR 1893—94.

During the past year the progress of the Medical School has been thoroughly satisfactory. The number of new entries has shown a slight increase over that in the preceding year, both as regards students entering for the full curriculum and those entering for particular departments of study.

Some changes in the Staff of the Hospital and Medical School have taken place. The vacancies created by Mr. Durham's promotion to the Consulting Staff have been filled by the election of Mr. Golding-Bird to be one of the Surgeons of the Hospital and of Mr. L. A. Dunn to be an Assistant-Surgeon. Mr. E. T. E. Hamilton has been appointed Demonstrator of Anatomy.

Owing to certain alterations in the scope of the Examination in Elementary Biology, which will come into force next session, the duties of the Demonstrators of Physiology and Biology have been re-arranged, and an additional Demonstratorship has been created.

With the object of giving more prominence to the teaching of Mental Physiology, it has been determined that a course of Practical Demonstrations in this subject shall be held at the commencement of the Winter Session. Dr. Rivers has been appointed to conduct this class, and to share with Dr. Savage the Winter Course of Lectures.

The success which has attended the institution a few years ago of Clerkships to the Anæsthetists, with the object of enabling a greater number of students to gain practical experience in this important department of professional study, has been so marked that at the end of last year the system was extended. For this purpose it was necessary to increase the number of Anæsthetists to the Hospital, and Mr. Hamilton, Dr. Lancaster, Mr. Ogle and Mr. Rowell were appointed to this office. It is now possible to provide that every student before leaving the Hospital shall have the opportunity of personally administering anæsthetics under due supervision.

The only other changes upon the Staff that remain to be recorded are the appointment of Dr. Starling to be Senior Demonstrator of Physiology and of Mr. G. B. Smith to be Surgical Registrar.

The alterations introduced in the subjects of the Examination for the Entrance Scholarships in Arts have proved satisfactory, a much larger number of candidates having competed last September than in any previous year.

This year for the first time will be awarded the Hilton Prizes for Dissection, which have been founded by an anonymous benefactor in memory of our illustrious Surgeon.

The School have to thank Mr. Durham for providing them with the means of continuing, for a further period of five years, the Prizes for Dissection, which were instituted by him in 1889.

It is a matter for regret that the competition for some of the medals and prizes which are to-day distributed has not been so keen as might have been wished, and that in two instances the Examiners have thought it right to recommend that the second prize usually given should not this year be awarded.

The Gull Studentship in Pathology, of the annual value of £150, which is awarded triennially, becomes vacant this year. The Board of Electors are satisfied that the research carried on by Mr. F. G. Hopkins during his tenure of the Studentship has led to valuable and important conclusions, and they have nominated Mr. Herbert E. Durham as his successor.

At the Examinations of the Universities and Royal Colleges, our students have fully maintained the reputation of the Hospital so far as the Pass Examinations are concerned, and although the number of Honours which have been gained is less than in some previous years, there are some notable successes to be recorded.

Mr. G. F. Still is to be congratulated on obtaining the Murchison Scholarship in Clinical Medicine, which is now for the first time brought to Guy's Hospital.

At the Intermediate Examination for the degree of Bachelor of Medicine at the University of London,

Mr. C. J. Harnett gained the Gold Medal and Exhibition in Physiology, together with Honours in all four subjects of the Examination; and Mr. Mumford obtained marks qualifying for the Exhibition in Organic Chemistry. At the Final Examination, Mr. J. A. Howard was placed in the First Division of the Honours list in both Medicine and Forensic Medicine, obtaining in the former subject marks qualifying for the Gold Medal.

The activity of the Dental School has been well maintained, and the percentage of successes amongst our Students at the examination held by the Royal College of Surgeons for their license in Dental Surgery has been higher than the average from all Schools. At the same time, the competition for prizes offered in our own School to Dental Students has been of a very satisfactory nature.

Our Football players are to be congratulated on winning for us the Inter-Hospital Association Cup, which has not been in our possession for several years. We look with confidence to our Cricket and Athletic Teams to retain the Challenge Cup and Shield which they won for us last year. It is gratifying to note that the Council of the Clubs' Union report that their ground at Honor Oak Park is in constant use by an increasing number of students, and that the various constituent Clubs of the Union are in a thoroughly efficient condition.

In conclusion, the Dean, on behalf of his colleagues, desires to thank the Treasurer and Governors of the Hospital for their unfailing interest in all that tends to the welfare of the Medical School.

THE DISTRIBUTION OF PRIZES.

At 3 p.m. a distinguished company, including most of the members of the Staff, assembled on the platform in the tent, when, in the presence of a large gathering, Dr. CLIFFORD ALLBUTT, F.R.S., LL.D., presented the Prizes and Certificates in the following order:—

The Treasurer's Gold Medal for Clinical Medicine.—John Alexander Howard, Canonbury.

The Treasurer's Gold Medal for Clinical Surgery.—Leopold Ernest Valentine Every-Clayton, Nelson, Lancashire.

Gurney-Hoare Prize for Clinical Study.—William James Harris, Calne, Wilts.

Beaney Prize for Pathology.—John Alexander Howard, Canonbury.

Michael Harris Prize for Anatomy.—Robert Pugh Rowlands, Towyn, N. Wales, Prize £10; Edmund Ivens Spriggs, Market Harborough, Certificate; John Abel Glover, South Lambeth, Certificate.

The Arthur Durham Prizes for Dissection.—First Year's Students.—Laurie Hugh McGavin, London, Prize £5; Frederick Edward Walker, Hampstead, Certificate. Second Year's Students.—Edmund Ivens Spriggs, Market Harborough; John Abel Glover, South Lambeth, equal, £7 10s. each; John Ownsworth Garland, Barnsley, Certificate; John Thomas Roberts, Llanfachreth, Certificate.

Fourth Year's Prizes.—Francis James Steward, Old Charlton, First Prize, £25; Benjamin Arthur Richmond, Liverpool, Certificate.

Third Year's Prizes.—Walter Charles Pakes, Garstang, First Prize, £25; Nolan Daly, Abingdon, Certificate.

Second Year's Prizes, 1893.—Walter Charles Pakes, Garstang, First Prize, £25; William Edwin Plummer, Tunbridge Wells, Second Prize, £10. Dental Students, 1894.—Herbert Wallis, Hull, Prize, £15; Urban Edward Cave, Newbury, Certificate.

First Year's Prizes, 1893.—Edmund Ivens Spriggs, Market Harborough, First Prize, £50; Robert Pugh Rowlands, Towyn, Second Prize, £25; Evan Evans, Aberayron, Certificate; John Abel Glover, South Lambeth, Certificate. Dental Students, 1894.—Joseph Lewin Payne, Kennington, and David Sydney Stevens, Stamford Hill, equal, £5 each; Clarence Albert Harry Keall, Notting Hill, Certificate; Arthur Wellesley Penrose, Highbury, Certificate.

Practical Dentistry Prize.—Lionel Frederick Morris, Newport, Mon., Prize, £10; Urban Edward Cave, Newbury, Certificate.

Open Scholarships in Arts.—Albert Evans Davies, Carmarthen, £100; Samuel Dainow, Highbury, £50. Dental Students.—Graham Scales Simpson, Brighton, £30.

Open Scholarships in Science.—Philip Turner, Earl's Court Gardens, £150; George Ernest Richmond, Leicester, £60; Frederick Edward Walker, Hampstead, Certificate.

The Distribution completed, Dr. CLIFFORD ALLBUTT, addressing the meeting, said:—

Mr. Treasurer, Ladies and Gentlemen,—The first words that you will wish to hear from me, I am sure, are words in the nature of a report on the health of my colleague, Sir George Humphry, who should have been here to-day to distribute the prizes, but was prevented from doing so on account of illness. We hope that illness is of a temporary kind. I cannot say that it has passed away, still less can I say his strength is restored; but when I went to see him yesterday, I found that he had been taken out for the first time for a drive, so I think we may all feel hopeful that the malady itself has passed

by, and that it is simply a question of a little time for his strength to be restored. Having said this, my next duty is to make a few brief remarks on the occasion which has brought us together to-day. Coming from Cambridge, it is somewhat difficult to attune oneself to an occasion of this kind. At Cambridge, during the past week, we have been engaged in a great deal of examination and prize giving it is true, but these had relation to the Royal Agricultural Show. Our talking and thinking has been entirely on agricultural subjects, and our examinations and prizes have dealt with the humbler part of creation. Thus, our minds having become permeated with matters agricultural, it is, as I have said, difficult to bring oneself back to the serious events of life as represented here to-day. In speaking of those serious things, it strikes me forcibly, on all these occasions, what a serious thing it is for a man to undertake the medical profession. Few men escape examinations, but few are submitted to such a long and trying series as those who dedicate themselves to our profession. And yet we may congratulate ourselves upon the bravery of our younger brethren who present themselves to undergo this long period of probation. For it is a very serious thing nowadays, the load that is placed upon the minds and strength of the young men who have just carried off these honourable and substantial prizes. I am bound to say that, notwithstanding what has been urged regarding the mental strain, I have not seen to-day, or in Cambridge, any signs of physical deterioration in those who have undergone this training. They come up merrily enough; they subject themselves to five years or more of work, and a curriculum which is probably three or four times as hard as that a man has to go through for any other profession, and yet they are as active merry young fellows as any members of the University. Therefore, although I have no intention of alarming these gentlemen by suggesting that we shall make the tests harder than ever, for I hope we shall not, yet I am glad they are not suffering from the effect of them. To-day we have seen the successes, and we are disposed to think, perhaps, that all the strain and labour falls on those who have won the prizes; but while our eyes are naturally fixed on them, we must remember also the hard work on the part of the great many men who have laboured quite as hard and industriously, and in their own way with, perhaps, as much ability, but who have not succeeded in gaining prizes; and there may be, in the cases of some persons, a certain pathetic element in the non-success, so far as prizes are concerned, of men of industry, intelligence, and ability. Yet, if I may judge from my own experience, we generally find our students free from jealousy or unkind rivalry in competitions of this kind. I do not think I can ever remember bitterness arising between the candidates for prizes or scholarships at the Universities. I think Englishmen can take these battles in good humour and win or lose with equanimity, and nothing can be better discipline for the sterner battle they will have to go through in the wider arena of the world. The first persons to applaud the winner are generally those who have been most conspicuous amongst the competitors for the prize. Therefore I, for one, am indisposed to admit that there is any force in the argument which holds that these prizes and examinations do harm in engendering bad blood between the candidates, but then the question comes, whether prizes in themselves are desirable, whatever the equanimity with which they are won or lost, and whether they go to the best men? As regards examinations, it is said that we are over examining people in every department in life, and attaching too much value to the results thus obtained. Well, I suppose no one asserts that an examination can test every part of life. I think it might, and probably would be said, that an examination can test the attainments of the candidates, but we might go a little further than that, and I should be disposed to deny that an examination was no test of character, as well as attainments. That an examination can be an all round test of character, is of course impossible, but there are certain elements of character it can, and does test, very well. It tests the rapidity with which results can be produced, and learning is no good unless it can be brought forth. It tests the decision and clear-headedness of the candidates, and it is also a test of order—all persons whose papers are well ordered have an advantage; and, without giving further instances, I do venture to hold that examinations do much towards testing those qualities of character which, I am bound to say, we in England value rather more than we value attainments. We are a practical people, and attach more importance to points of character than to the accumulation of knowledge. It is no reproach to examinations to say that they do not test things they were never intended to test. There are some men who, however able, and turning out extremely successful in after-life, do not distinguish themselves in examinations, and if any pathetic interest attaches to failure, it is in the case of those who for some reason or other, do not do themselves full justice in examination. These are often men of very considerable ability and originality; they swerve somewhat from the ordinary rucks of study; their fancy is taken; they are charmed by some aspect of a thing and they follow it.

I fancy John Hunter would have passed a very bad examination; but such men are the minority, and I do not think it is at all injurious to them to have to undergo the discipline of examinations. A man who has a touch of genius, who is a little eccentric or wilful in his study, is not worse, but rather better, for such ordeals, which force him to broaden his field of study, and strengthen it where it is weak, for that formative discipline which prevents his yielding too much to his bent. Those are the main points which occur to me as bearing upon the very much agitated question of the value of examinations. Naturally, being an examiner myself, I am inclined to magnify my office. Some reference, however, may be made to the very great change coming over the character of medical examinations. The time has gone by now when the sort of education obtained in the old days of apprenticeship will succeed. That was called a practical education. Now, none of us underrate practice; but what I am referring to was rule of thumb doctrine, which must necessarily give way to an education resting upon a more accurate and scientific basis. We do not now learn so much from traditional lectures, from people who hand down secrets of their craft, but men are now taught in the laboratories to investigate and think for themselves, to weigh everything, and distrust everything that cannot prove itself. On the other hand, we know medicine is an applied art which cannot rest solely on a scientific basis. If we were to confine our patients to those things we scientifically know, we should deprive them of much great value. There is still traditional lore. That such and such a thing is good for such and such a complaint. Why it acts, no one knows. No one knew till a little time ago why quinine cured ague. But the time has gone by when a man can rely upon those points of practical sagacity, for they cover now but a comparatively small ground, and that ground is getting smaller every year. We welcome the expectation that in the early future probably a very much larger amount of our work, and the things we do to help people, will be explained and placed upon a scientific basis and used with better results. This is true of every sphere of scientific action. We find that men cannot continue acting on traditional or rule of thumb teaching, but must begin from the beginning. In this way medical education is undergoing a great change, which entails the increasingly laborious course our students have to go through. The interest of some students is in direction of dry scientific investigations, things seen in the dry light of proposition, and they interest themselves in discoveries in the region of what was called practical philosophy, while others are more interested in the practical application of these things. Some of you who are now going out into the world are animated with considerable ambition, which I should be the last to repress—ambition to gain power, place, influence, and ascendency over others, excellent things in their way if the end to be attained is unselfish, and in the public interest. But there are also some, a minority, a rare class of men, but possibly the more elect, who care less for the successes of the present, and think more of the discoveries of the future, who prefer, "enamoured of the bright countenance of truth, to spend their days in still and peaceful study." The latter class look forward to discoveries in the future, but they would find their task gone if it were not for the large class of practical workers who are taking care of the present in the meantime. To all I would commend the ideal portrayed by Aristotle, that the part we ought to bear in the world is to try and play the immortal, by which he means we should try to make our faculties as perfect as we can, and then adapt them to the most perfect end we can comprehend; and if we do that we shall approach as near the immortal as we may in this world, and I trust and hope that the students of Guy's Hospital may always be animated by so noble an ideal.

The TREASURER.—I rise to propose a cordial vote of thanks to Dr. Clifford Allbutt for the very interesting address he has given us. The Governors feel highly honoured that a gentleman of his vast attainments and perpetual employment should have come here to-day, no doubt, at a sacrifice to himself. I may take this opportunity of mentioning that among the distinguished company present I believe we have the Prime Warden and other officers of the Salters' Company. Lately this Company have, in a most liberal manner, endowed five beds in this Hospital in perpetuity. I believe this is the first time since the foundation of Guy's Hospital that any one of the City Companies has taken such a living interest in the patients of this institution. Many of the City Companies have, indeed, generously given us of their wealth and subscribed to our needs, but never before has any Company determined on having beds of their own within our wards. The Governors hail the new departure with gratitude. They would like to see other Companies, or private individuals, following so good a precedent. Guy, himself, belonged to one of the City Companies, and I feel he would have rejoiced to know what the Salters' Company have done for the institution which he founded.

Dr. PYE-SMITH.—I am very proud to play the part of seconder of the motion proposed by my old friend Mr. Lushington. You will agree that we owe Professor Clifford Allbutt sincere thanks for coming at a short

notice, for his presiding so well, and for his wise words which will remain in the hearts of those who have to-day received their distinctions. We believe that what he said of the generous rivalry, which none of these distinctions can ever impair, is very true in the school he adorns at Cambridge and here at Guy's. I, myself, was beaten at the M.D. examination by a fellow student; but his success was so well-earned, and he bore it so modestly, that it never interrupted the friendship we had as young men, which has continued to the present moment, for that student was our friend Dr. Thomas Stevenson. I am sure we also agree with what Professor Clifford Allbutt said in defence of the examination system, that much decried method of showing who is the best man, at all events in the subjects that examinations can reach, and also that when combined with teaching, the examination is a most potent help and education. We do not hold what a friend of mine, a distinguished graduate of Oxford, once said, that he did not believe in teaching or examinations, for he remarked, the more you teach the less they learn, and the more they learn the less they know. We act on the principle that the more we teach the more will the students know, and that will more certainly be the case if they will teach themselves, for the utmost any teacher can do is to exercise the midwife's art, and bring forth the latent powers of each man. And, lastly, we thank Professor Clifford Allbutt for the manner in which he put before you the conditions of success, and if any man may speak with authority upon that subject, it is Professor Clifford Allbutt. Follow that advice, and you will attain to the greatest measure of success to which your talents and powers are equal.

Mr. HOWSE, in supporting the motion, said:—I can recollect Dr. Clifford Allbutt being quoted in scientific matters ever since I was a student. I do not wish to appear to attribute too great an antiquity to Dr. Clifford Allbutt; he might not thank me, for that was a good many years ago. Now he comes to us as Regius Professor of Medicine in the University of Cambridge; and we hope this may be the means of still further drawing together this Hospital and the older University. Many years ago one of my student colleagues, an Oxford man, expressed to me, soon after entering here, his great surprise at the way the term *the* University was used here. His imagination regarding a university had been limited to his own and possibly Cambridge. When he came to Guy's he heard continually of men going up to the University, by which was meant, not Oxford or Cambridge, but London, which was *the* University in the eyes of Guy's men. At that time it was no doubt true that the vast majority of our men went in for London; but it is not equally true now. I am glad to see round me so many of the old students belouging to the Universities of Oxford and Cambridge: and I do not think that in the future it is likely that this number will be lessened. I hope the union may be drawn closer; and I say this in the face of the fact that we are trying here to build up in London a greater University than now exists. If we succeed in this it will be a great and important thing for all students of our London hospitals, because we have heard to-day that prizes are not altogether bad things as stimulating men to further study, and an University degree is a great prize. If, therefore, we can sweep a net around the best of our students, and set them at gaining University degrees, we shall be doing the best thing for our students and the profession at large hereafter.

The vote of thanks having been carried with acclamation—

Dr. CLIFFORD ALLBUTT briefly replied.—He welcomed the expressions of hope for continued co-operation between the University of Cambridge and Guy's Hospital. At Cambridge they were terribly in want of a millionaire to assist their Medical School, and he said this because people here would now be giving all their money to the New University. Still Cambridge would battle to hold its own and keep in the forefront of scientific progress.

Gull Studentship in Pathology.

NOTICE is hereby given that Mr. Herbert Durham, M.B., B.C., F.R.C.S., has been elected the Gull Student.

L. E. SHAW,
Secretary to the Board of Electors.

Guy's Hospital Bicycle Club.

MR. GOLDING-BIRD'S run has been altered by request, from July 7th to July 21st, and the Dunton Green run will be held on the 28th, instead of the 21st inst.

Members intending to be present are requested to put their names down in the case.

The cross country ride from Bromley to Gravesend last month, to visit the U.S.S., Chicago, was the most enjoyable of the season so far. The members present were shown over and entertained on board by Medical Inspector Du Bois (by whose invitation the visit was made), and several other cycling officers, of whom there were about a dozen in the ship, six of them having their machines with them.

To-day's run is to Ripley, starting from Streatham Church at 3 p.m.

Appointments.

The following appointments have been made by the Treasurer:—

House Physicians.—Mr. L. Slater (Dr. Taylor); Mr. A. Chaning-Pearce (Dr. Goodhart).

House Surgeons.—Mr. G. Lawrence (Mr. Lucas); Mr. W. Poole (Mr. Golding-Bird).

Assistant House Physicians.—Messrs. H. A. Duffett and H. M. Stewart.

Assistant House Surgeons.—Messrs. R. H. Fagge and E. F. H. Hardenberg.

Resident Obstetrics.—Messrs. D. M. Beddoe (July); R. H. Luce (August); F. J. Coleman (September).

The following appointments have been recommended by the Medical Council, and approved by the Treasurer:—

Clinical Assistants.—Messrs. A. J. Collis, C. C. Jenkins, L. A. Parry, W. E. Robinson, W. A. L. Smith, P. McK. C. Wilmot.

Dressers in the Eye Wards.—Messrs. H. A. Munro, E. A. Peters (Mr. Higgens) (July); L. E. V. Every-Clayton, A. H. Leete (Mr. Brailey) (July); C. H. Bryant, F. Zumbado (Mr. Higgens) (September); J. H. Horton, G. E. Manning (Mr. Brailey) (September).

Surgeons' Dressers.—Messrs. E. Coleman, G. L. Eastes, H. R. T. Fort, R. H. Hayes, B. W. M. A. Key, A. A. Price (Mr. Howse); B. B. Ham, R. O. Moon, B. F. Pendred, F. R. Proctor-Sims, W. J. Rowland, L. H. Y. Stephen (Mr. Davies-Colley); A. P. Beddard, H. A. Moffat, W. G. Mumford, W. C. C. Pakes, A. A. H. Partridge, T. M. Thomas (M. Lucas); W. L. B. Davies, J. W. Ensor, W. W. Henson, R. L. Roberts, E. H. Tipper, H. M. Wise (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. R. H. Ashwin, R. E. Delbruck, H. W. Dudgeon, J. O. Garland, P. H. Haylett, P. E. Tresidder (Mr. Jacobson); J. A. Glover, C. J. Harnett, G. B. Muriel, F. J. Thomas, W. Tyson, G. B. Webb (Mr. Symonds); F. J. H. Cann, C. R. Evans, J. Hora, C. H. Hunter, B. P. O'Neill, P. N. Vellacott (Mr. Lane); O. Beven, G. Burton-Brown, C. D. Edwards, M. C. Hayward, L. T. A. Rowland, H. J. Spon (Mr. Dunn).

Medical Ward Clerks.—Messrs. H. Alexander, H. T. S. Bell, R. T. Brown, C. G. Burton, A. G. Butler, P. J. Curtis, T. Davies, W. R. Davies, H. S. Desprez, C. H. Fagge, W. W. Farnfield, H. P. Ferraby, A. H. Finch, J. J. Foster, H. Fulham-Turner, F. A. Godson, E. D. Hancock, W. I. Hancock, R. Hedden, T. L. Jackson, F. J. Lidderdale, L. C. Panting, J. B. Parfitt, N. H. Pike, P. C. Prince, W. Ramsden, J. Robertson, F. W. Rowland, E. N. Scott, E. T. Scowby, M. H. Smith, A. H. Spicer, C. C. Stead, F. W. Ta'Bois, P. G. Temple, T. J. A. Tulk-Hart.

Assistant Physicians' Clerks.—Messrs. A. J. Dolman, W. A. Horton, A. S. J. Pearse, T. W. Stanton (Dr. Pitt); C. Coventry, S. G. Layman, J. C. G. Reed, C. E. S. Watson (Dr. Shaw); G. F. Birdwood, F. H. Hardy, W. L. Stuart (Dr. Washbourn).

Aural Surgeon's Dressers.—Messrs. C. S. Bond, C. A. Ensor.

Dental Surgeons' Dressers.—Messrs. H. W. Beach (July), F. S. Brereton (August), F. Loud (September).

Dressers in the Throat Department.—Messrs. L. C. Burrell, G. H. Field, C. J. Kearney, J. R. Steinhaeuser.

Post Mortem Clerks.—Messrs. E. R. Fothergill, L. G. Reynolds (July and August); B. A. Richmond (September and October).

Obstetric Ward Clerk.—Messrs. T. B. Poole, W. F. Reckitt, A. Salter.

Obstetric Out-Patients' Clerks.—Messrs. J. H. Horton, H. J. Milbank Smith, C. B. Statham (first half), J. C. Constable, J. G. O. H. Lane, H. Pern (second half).

Surgical Ward Clerks.—Messr. F. S. Batchelor, A. B. Carter, J. N. Gardiner, H. T. Hicks, W. E. Hills, C. Jephcott, C. E. Michael, A. W. Ormond, W. E. Plummer, W. C. Pritchard, D. Rice, A. M. Rygate, H. V. Smith, W. E. Waymark, W. R. Wood.

Assistant Surgeons' Clerks.—Messrs. C. H. Fagge, S. G. Graham (Mr. Jacobson); C. A. C. Askew (Mr. Symonds).

Clerks in the Skin Department.—Messrs. S. G. Graham, R. Henderson.

Externs.—Messrs. R. F. Clark, E. Coleman, H. M. Wise, E. H. Tipper, W. C. C. Pakes, R. O. Moon.

Assistant Demonstrators of Anatomy.—Messrs. J. O. Garland, G. B. Webb.

Assistant Demonstrator of Physiology.—Mr. J. B. Leathes.

Prosectors.—Messrs. L. E. C. Handson, L. H. McGavin, S. A. Ruzzak (Mr. Lucas) (October–December); H. W. Bruce, O. Marriot, F. E. Walker (Mr. Jacobson) (October–December); V. J. Crawford, G. E. Richmond, C. B. Thomson (Mr. Lucas) (January–March); J. A. Glover, W. T. Milton, P. Turner (Mr. Jacobson) (January–March).

Dental Appointments.

Curator of Laboratory.—Mr. E. C. Dimock.

Dressers in the Gas Room (July).—Messrs. A. J. Collett, A. F. A. Howe, C. A. H. Keall.

Dressers in the Ordinary Extraction Room (July).—Messrs. N. Denham, E. C. Dimock, J. W. Lewis, H. D. Mathews, A. W. Penrose, E. R. Tebbitt.

Demonstratorship of Physiology.

We hear on going to press that Mr. F. G. Hopkins has been officially appointed to this vacant post. We feel sure that no more popular nor satisfactory appointment could have been made for the good of the Medical School.

Passim.

Everyone will regret the cause which prevented Sir George Humphry from presenting the prizes on Wednesday last, and we are sure that we are expressing a universal hope in wishing the distinguished surgeon a speedy recovery from his severe illness.

Guy's was fortunate in securing the honour of the presence of Dr. Clifford Allbutt to distribute the prizes in the place of Sir George Humphry. Educated at Cambridge, St. George's, and Paris, Dr. Allbutt has had a distinguished career. He was made Fellow of his College, and is also Regius Professor of Physic at Cambridge University. He was elected a F.R.S., F.S.A., and is also F.R.C.P., F.L.S., and the author of many valuable papers on scientific and medical subjects. His address on Wednesday, which we are able to present in this issue, was listened to with interest by the large company in the tent, and will afford food for reflection to all those who were unable to hear it then.

There is one feature of Prize Day that none of us ever see on other days. We refer to the "Fountain"; this ancient land—or should we say water—mark has been doing its duty nobly for years on this one particular day. This year, however, it seemed determined to make itself better appreciated, and so struck work while the band played. This disinclination for work has made us feel that the water might be allowed to play on other occasions. It would, we are sure, be a great boon to the patients if the water was turned on, at any rate in the hot weather, say for two hours every afternoon. There would then be no reason nor inclination on its part to strike when wanted on an important occasion such as Prize Day.

The Biennial Dinner, a full account of which we shall insert in our next issue, was held on Wednesday last, at the Whitehall Rooms, Hôtel Métropole. In the unavoidable absence of Dr. Taylor, Mr. Davies-Colley took the chair and received all the visitors, who numbered close upon 230. Save for some confusion early in the evening through the programmes arriving very late, everything was excellent—dinner, wine, and speeches—and a most enjoyable and social gathering was spent.

The Laundry Hostel, a brief account of the opening of which we give elsewhere, fills a long felt want in the work of the Hospital Laundry. We are glad to learn that it will be self-supporting, and its opening by the Lord Bishop of Rochester, under such happy auspices, augurs well for its success in the future. The Hostel was universally pronounced to be a charming "home," light and cheerful as a home should be. That the building should once have been in use as a stable, is hardly credible, so great has been its transformation, in accordance with the able plans of Mr. J. H. T. Woodd.

Last week our attention was called to a paragraph in an evening paper containing a letter purporting to be "written by a feminine student of medicine" to an examiner at one of the recent examinations for a medical diploma. Even if the expressions used by the deferred candidate *were* meant, it was hardly chivalrous of the paragraphist to hold the letter as expressing the sentiments of all female suffragists, and we should be doing an injustice to "our weaker brethern" in the profession not to raise an indignant protest against the publication of such stuff, tending, as it does, to cast a slur altogether uncalled for on the female members of a noble profession.

WE offer our heartiest congratulations to Mr. Herbert Durham, who has been elected the Gull Student in succession to Mr. F. G. Hopkins. We have also to congratulate the successful competitors for the Dental Prizes, Messrs. Morris, Wallis, Payne, and D. S. Stevens. Mr. H. Wallis has done remarkably well, having now secured both First and Second Year's Prizes. Mr. Cave, who has been just behind Mr. Wallis right through, is to be complimented on having obtained a Certificate in each of the three Prize Classes for Dental Students. We should also like to show our sense of appreciation of the fact that two of the four first candidates for the First Year's Dental Prize are also Medical Students, which speaks volumes for the good work they must have put in.

ALL Guyites will join us in wishing every happiness to Mr. Alfred Allport on the occasion of his marriage with Miss Edith Fry. The ceremony was, we understand, quite a quiet one, and though expected was none the less a bit of a surprise. That Mr. and Mrs. Allport may live long to enjoy a happy and prosperous existence is but to re-echo, we are sure, the good wishes of all.

THE Pass List in our last issue should have included the name of Mr. E. H. Cartwright as having taken his M.D. Oxon., and we regret the omission.

WE are more than interested to hear that Mr. Reginald Koettlitz has been appointed Medical Officer to the Jackson-Harmsworth North Polar Expedition. The idea of a Polar Expedition at least, to those not in the know, is a refreshing and invigorating one indeed, now that we are sweltering in the London heat. We trust that Dr. Koettlitz may not only find it so, but that the expedition may meet with the success that its intrepid explorers hope for. We are always glad to hear from old Guy's men, and should Mr. Koettlitz contemplate recording any of his experiences, may we hope that he will not forget the ever-open columns of the GAZETTE. We are sure that any of his contributions will be read with interest by all Guyites, old and new.

WE should like to suggest that a Central News Tape Machine would add greatly to the value of the Club. We are informed that a small annual outlay will cover the cost; and when it is considered what a saving to many it would cause in evening papers alone, there really seems no objection to its institution in the Smoking-room. By its means we should be kept informed of all the latest news without any trouble or time lost in vainly hunting through files of newspapers to peruse, for which we find less time every day at our disposal. We have taken this opportunity of suggesting the idea, and even if the Students' Club Committee cannot at present see its way to adopt our suggestion, no harm will have been done in bringing the matter before their notice.

WE have just heard of a quite new departure on the part of our Dental Colleagues. They propose to get up an up-river picnic on a large scale, and a committee meeting of the Dental House-Surgeons was held on Thursday last to discuss the arrangements. The present suggestion is that they shall go up the river as far as Staines, and there hold an impromptu smoker before returning. The date provisionally fixed upon was Saturday, the 14th inst. This commends itself to us as an excellent idea, and we wish our Dental friends a most successful and enjoyable day's outing.

The Diagnosis of Diphtheria.

The difficulties of diagnosing diphtheria from a clinical examination are well known. Even when a well-defined membrane is present it is often impossible to say whether the case is one of true diphtheria. Still greater difficulties arise when the exudation is of a pultaceous nature.

The only reliable method of arriving at a diagnosis is by means of a bacteriological examination. Should the Klebs Loeffler bacillus be found, then the case is certainly one of true diphtheria. This bacillus cannot be distinguished by a simple microscopical examination, but can be recognised by its mode of growth in culture media.

Cultivations are made from the exudation on the surface of coagulated blood-serum. The culture is then incubated for twelve hours at the body temperature. If diphtheria bacilli are present, large white colonies appear at the end of that time. Cover glass preparations from these colonies reveal the characteristic form of the Klebs Loeffler bacillus.

A skilled bacteriologist can in this way readily diagnose cases of true diphtheria by examining the fresh exudation.

We have made arrangements with our Pathologist to examine by this method specimens forwarded to him.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Nervous system.

Stephen	10.	Hysteria. ? Insular sclerosis.
	11.	Right hemiplegia.
	12.	Cerebral tumour. Optic neuritis.
	17.	Myelitis.
	21.	Locomotor ataxy.
	22.	Left hemiplegia.
	24.	Paraplegia.
	25.	Diphtheritic paralysis.
	29.	Myelitis.
	36.	Oculomotor paralysis. Fits.
Philip	9.	Chorea.
	11.	Right hemiplegia.
	16.	Cerebral syphilis.
	25.	Cerebral tumour.
Mary	8.	? Locomotor ataxy.
	17 & 19.	Chorea.
	42.	Myelitis.

Respiratory System.

Stephen	13.	Broncho-pneumonia.
	20.	Bronchitis and emphysema. Pleurisy.
	34.	Pneumonia.
	35.	Empyema.
Philip	37.	Bronchitis.
Mary	9.	Broncho-pneumonia. Mitral regurgitation.
	43.	Bronchiectasis.

Phthisis.

Stephen	4.	
Philip	7, 10, 13, 15, 29.	
Mary	1, 31, 45, 48.	

Circulatory System.

Stephen	2.	Ulcerative endocarditis.
	8.	Mitral stenosis and regurgitation.
	16.	Mitral regurgitation.
	18.	? Ulcerative endocarditis.
Philip	22.	Aortic stenosis and regurgitation. Mitral regurgitation.
	23.	Aortic stenosis. Ulcerated leg.
Mary	5.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	18.	Anæmia. Chlorosis.
	24.	Aortic and mitral regurgitation.
	41.	Adherent pericardium.

Alimentary system and abdomen.

Stephen	6 & 19.	Tuberculous peritonitis.
	31 & 32.	Dysentery.
	39.	Carcinoma of stomach.
Philip	12.	Enlarged spleen.
	17.	Carcinoma of pylorus. Secondary growths in the liver.
Mary	3.	Perityphlitis.
	7.	Abscess about gall bladder.
	13.	Gall stones
	32.	Abdominal tumour. Moveable kidney. Enlarged liver.
	44.	Ascites. ? Cirrhosis.
	49.	Dilated stomach.
	50.	Tuberculous peritonitis.

Genito-Urinary.

Stephen	5.	Renal calculus.
	7.	Granular kidney. Gout.
	14.	Renal tumour. ? Tuberculous kidney.
	15.	Diabetes mellitus.
	28.	? Renal calculus.
	40.	Chronic Bright.
Philip	3.	Granular kidney. Gout.
	5.	Chronic nephritis.
	19.	Diabetes.
Mary	4.	Chronic tubal nephritis.
	37.	Chronic nephritis.

Acute Rheumatism.

Stephen	1, 9, 30.
Philip	27, 34.

Miscellaneous.

Philip	2. ? Tuberculosis.
	6. Rheumatoid arthritis.
	31, 33. Gout.
Mary	36. Tuberculous ulceration of skin.
	30. Acute eczema.
	39. Rheumatoid arthritis.

Cases under Dr. Taylor.

Stephen.

3. G. G., æt. 61, bachelor, engine driver in a brewery, was admitted under Mr. Symonds into Samaritan 8 with ulceration of the feet and toes; transferred a few days after, *i.e.*, June 8th, to Stephen.

Had been admitted into Naaman with ulceration of feet, and transferred to Stephen 19, under Dr. Perry, July 12th, 1893, with glycosuria and albuminuria. The glycosuria never went beyond 10·5 parts per 1,000; the total amount of sugar passed in twenty-four hours never beyond 442 grs. With diabetic diet, the total quantity of sugar passed in twenty-four hours fluctuated, but fell considerably lower than before. Patient left the wards to become an out-patient August 19th, with 38·3 grs. of sugar in the urine. The ulcers had rapidly healed up. There had been one below the right middle toe, about the size of a sixpence, surrounded by thick epidermis; its floor was red and unhealthy, but there was no gangrene or defective circulation.

Previous to this, patient had never been unwell.

On admission into Stephen 3, there was a slight dry cough, orthopnœa, œdema of eye-lids, legs and a well-marked lumbar cushion. Pulse 112; hard, full, incompressible, and its tracing typical of Chronic Bright. Urine scanty, pale, with slight deposit, and specific gravity 1014; albuminous (6 parts per 1000), but not one of the sugar-tests gave positive results. The microscope showed a few finely granular casts. The lungs were somewhat dull at the extreme bases, where fine râles and deficient entry of air were also made out. On the right foot there were three ulcers, two on big toe and one along the inner border. One of the former was quite superficial; the other led down to bare bone. On the left there was a small superficial ulcer beneath the big toe. The soles of both feet were enormously thickened.

Treatment.—Fish diet. Linctus Belladon. ℥j. p.r.n., hot boracic lint and Jeye's powder to ulcers. Pulv. Jalapæ Co. gr. xl. o.a.m., and the following mixture:—

℞ Mist. Senegæ	... ...	℥ss.
Ammon. Carb.	...	gr. ij½.
Tinct. Seneg.	... ...	♏ 15.
Lig. Ammon. Acet.	...	℥ij.
Mist. Ammon. Acet.	...	ad. ℥. 4tis horis.

Under this treatment the ulcers rapidly healed, enormous quantities of urine were excreted, *e.g.*, 100, 108, 128, etc., the œdema of face and legs entirely subsided, cough disappeared, breathing became easy, and, but for obstinacy of the bowels, patient is almost perfectly well.

Mary.

44. M. A. M., æt. 51. Has been married twice, but has never been pregnant. Her friends say that she has drunk beer freely. No previous illness, except winter cough. Present illness commenced in the spring of 1893, as pain under left breast and swelling of abdomen. Later swelling of feet, vomiting after breakfast. No jaundice. When first admitted, March 6th, 1894, patient's abdomen was uniformly distended (girth forty-two inches), dull everywhere, except close to the umbilicus. A well-marked thrill was obtained. Neither liver nor spleen could be felt. A systolic bruit could be heard at the apex, and in the aortic area. She was tapped. Fluid not clear, but transparent, tinged with blood. After tapping the liver could be felt, and nodular lumps were found. She was found to be somewhat delirious for some days after the first tapping. Since the first admission she has been obliged to return to the hospital every week or so for tapping.

Dates of Paracentesis:—

March 6th	...	Oj xvii ℥ x.
March 27th	...	Oj xx.
April 12th	...	Oj xviii.
April 27th	...	Oj xix ℥ viii.
May 6th	...	
May 11th	...	Oj xix ℥ ii.
May 24th	...	Oj xvi.
June 5th	...	Oj xii.
June 8th	...	Oj xxi.
June 23rd	...	

Re-admitted July 2nd. Abdomen (40 inches in girth) is again increasing in size and tension. The bruits remain as before. Patient somewhat delirious.

Cases under Dr. Goodhart.

Philip.

8. Patient is a fireman, aged fifty-one. Family history is good. Has had ague. Four months ago patient was quite healthy. The present illness commenced suddenly, with pains in both lumbar regions, and these were so bad the patient was unable to walk. Since taking to his bed he has lost weight *to the extent of one stone in the four months*. *Chest.*—Emphysematous, otherwise normal. *Heart.*—Double second sound at apex. He has occasionally expectorated a *little tough* mucus, with streaks of *blood* in it. Pulse 110. Temperature 97·8. He complains of pain on pressing iliac crest together, also on separating them. No tumor can be felt in the abdomen. Liver and spleen not enlarged. *Urine* is pale; specific gravity 1010; a trace of albumen. Patient has a sore about the size of a two-shilling piece over the interior condyle of right humerus.

In the Surgical Wards.

Cases Under Mr. Howse.

Charity.

W. A. B., æt. 4 months. Congenital cystic swelling in neck.

R. H., æt. 2 months. Talipes equino-varus (congenital).

F. S. æt. 3. Morbus Coxæ.

Naaman.

H. P., æt. 5. Cleft palate.

A. M., æt. 10. Ankylosis of ankle. Great wasting of leg.

W. A. K., æt. 53. Hard mass of growth at root of neck, pressing on sympathetic, recurrent laryngeal, etc. Gummatous or malignant growth.

Cases under Mr. Davies-Colley.

Luke.

G. A., æt. 42. Stricture. Extravasation of urine.

W. E., æt. 37. Femoral hernia, reducible. Abscess in perineum.

H. B., æt. 25. Very large mass of tubercular glands on left side of neck. Right side recently operated upon and cleared.

W. P., æt. 19. History of operation for hæmotocele. Enlarged painful testicle resulting. Castration.

Cases under Mr. Lucas.

Job.

W. B., æt. 57. Hydrocele.

J. H., æt. 18. Varicocele.

R. F., æt. 21. Old injury to elbow. Hard swelling at upper end of radius, limiting movements of elbow. ? Sarcoma or callus.

A. K. A., æt. 48. Stricture of urethra. Sinuses in scrotum and perineum. Cock's operation.

J. P., æt. 45. Hard swelling in groin. History of sudden onset with vomiting and constipation. Explored. Found to be an inflamed gland.

Charity.

J. E. G., æt. 43. Carcinoma mammæ.

W. K., æt. 42. Varicose veins.

Cases under Mr. Golding-Bird.

Martha.

M. H., æt. 38. Fractured patella.

F. A., æt. 2, and W. H., æt. 1½. Fractured femur.

H. C., æt. 52. Inguinal hernia. Radical cure.

A. E. D., æt. 1 5/12. Acute arthritis of right hip-joint after measles; probably secondary to epiphysitis. Head of femur detached.

E. F., æt. 31. Appendicitis. Large hard swelling in right iliac fossa. Explored. No pus. Small calculus found lying imbedded in firm fibrous tissue.

W. B., æt. 27. Keloid on forehead appearing in chicken-pox scar. Ulcerated in centre. Is the ulceration epitheliomatous?

C. M., æt. 67. Rheumatoid arthritis. Injury to right hip. Shortening, eversion, etc. ? Fracture of neck of femur.

E. L., æt. 27. Fibrous stricture of rectum. Colotomy.

Lazarus.

G. H. C., æt. 63. Malignant growth in parotid region.

R. J., æt. 26. Tubercular testicle.

A. P., æt. 20. Double pes cavus.

Case under Mr. Jacobson.

Naaman.

T. M., æt. 54. Epithelioma linguæ. Excision of tongue.

Cases under Mr. Symonds.

Luke.

J. H., æt. 19. Obstruction in naso-pharynx. Sarcoma of superior maxilla, etc. Growth removed with portion of superior maxilla, etc.

E. F., æt. 15. Large fibrous growth filling naso-pharynx. Removal.

Case under Mr, Lane.

Job.

J. McI., æt. 12. History of blow on head. Optic neuritis. Giddiness; weakness; pain in head. Diagnosis?

Correspondence.

To the Editor of Guy's Hospital Gazette.

Guy's Hospital Christian Union.

Dear Sir,—I shall be glad if you will allow me, through the medium of your columns, to heartily thank an anonymous donor for the sum of half-a-sovereign received about three weeks ago in aid of the above Union.—Yours very truly.

C. F. WAKEFIELD, Hon. Sec.

The College Letters.

Dear Sir,—The Gazette has been instrumental for our good on so many occasions, that I venture to bring to your notice the very grave inconvenience frequently caused by the delay in the delivery of letters and telegrams addressed to the Hospital for residents in the College. Delivered at 8 a.m., they appear in College window between 10 and 11 a.m., when many have looked in vain for letters at 9 or 9.30, so it often happens you do not get your letters till the afternoon. If you expect an important communication you ask at the College, and the reply is "letters have not come over yet," if you go to the Hospital you hear "letters have gone over," back you go again to the College and find they have not yet arrived, a process which sometimes takes two hours. Letters and telegrams delivered in the Hospital after the

first post, remain to be sent over late next morning. I could give a number of serious inconveniences caused by this lack of system, but will trespass no more on your space.—Yours sincerely,

"ONE LIVING IN THE COLLEGE."

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra amount of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps which have been sterilised by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

A. R. M., EAST RUDHAM. — The nodule beneath epidermis consists of fibrous tissue with patches of pigment. There are some inflammatory changes around the vessels, but no evidence of malignancy.

A. R. M., ROCHESTER.—Tubercle bacilli present.

R. M., BOLTON.—The growth is an adeno-sarcoma. The sarcomatous cells are of the medium sized spindle variety, and the growth is a rapid one.

F. H. K., HUDDERSFIELD.—The growth from the nose is an epithelioma, and comprised the growing edge. The perineal specimen was reported on in the previous GAZETTE. Many thanks for details of case.

G. F. H., BALHAM.—No tubercle recognised in specimen from B.

H. A. D., NEWTON ABBOTT.—There was a certain amount of pus in the urine. Tubercle bacilli were not recognised. There was no crystalline precipitate, or evidence of ulceration.

R. C. H., MIDHURST.—No tubercle bacilli were found in the sputum sent, but a large number of putrefactive organisms were present. No malignant cells were recognised.

W. L. C., SANDGATE.—Tubercle bacilli present.

C. B. B., HUDDERSFIELD.—The tumour is encapsuled around the greater part of the periphery. The structure consists mostly of mature connective tissue, surrounding glandular tubules. In two places these tubules are infiltrating the surrounding tissue, and lead to a view of adeno carcimonia.

PATHOLOGIST.

The Laundry Hostel.

THIS institution, we learn from the interesting pamphlet issued by the Treasurer on the opening day, is the outcome of a scheme which has for some considerable time exercised the minds of the authorities. So far as construction, machinery, and appliances go, the laundry seems to be well equipped. Complaints of bad washing, and especially of thefts of blankets, etc., to the extent of about £100 per annum, have rendered necessary some changes in the employment and management of suitable women as laundresses. The Treasurer accordingly determined that the staff of the laundry should live within the precincts of the Hospital in a Home, which should be under the supervision of a competent mistress.

Fortunately, at a time when the pressure of the situation was becoming intolerable, an opportunity presented itself of acquiring at a reasonable outlay a building lying immediately outside the Hospital boundary, and as regards size and position everything that could be desired for a Laundresses' Home. This building, purchased for the sum of £2,100, has been converted into a Laundry Hostel, at a further cost of about £1,500, in accordance with the plans of Mr. J. H. T. Woodd, the surveyor to the Hospital, the hot-water and heating apparatus being designed by Mr. T. Kirkland, engineer, of 17, Victoria Street, Westminster.

The Hostel stands upon a site in the old King's Head Yard, from which it has its principal entrance, though there is a second door opening directly from the Hospital. The ground floor is occupied by a large recreation-room for use in the evening, by the mistress's sitting-room, and by the heating chamber. On the first floor is the dining-room, with serving-room, lavatory, bath-room, and the smaller dormitory having five cubicles overlooked from the mistress's bedroom. On the second floor is the large dormitory, divided into thirteen cubicles, with the head laundress's bedroom, a lavatory, and bath-room. At the top of the building are the kitchen, scullery, larder, etc., together with several small bedrooms. An outside lift conveys coals and provisions up to the kitchen, and there is a second lift between the kitchen and dining-room beneath.

We understand that financially the future of the scheme is assured, as the Treasurer gained the consent of the trustees of the Spicer bequest to the proposal to use some of the money in their hands upon the purchase of the Hostel, interest upon the capital thus expended being guaranteed by the Hospital, and such interest being applied in accordance with the terms of the legacy for the relief of convalescent patients on their discharge. In this way both capital and interest are made available for the good of those whom Mr. Henry Spicer assigned by his will to benefit.

* * * * *

The scheme itself, so far as he (the Treasurer) knows, is one which no other large hospital has hitherto

attempted, and much, therefore, has still to be learnt by experience. That it can be so carried out as to conduce to the direct benefit of the Institution by improving the state of the laundry, and that it may be made of no small utility as a philanthropic enterprise, he has no doubt; and in this connection he congratulates himself upon having enlisted the warm sympathy of the matron, the sisters, and nurses in the enterprise, and upon obtaining the services of Nurse Evans, the late Dormitory Matron, as the first Mistress of the Laundry Hostel.

THE OPENING CEREMONY.

THE opening ceremony of the Laundry Hostel, the latest institution at Guy's Hospital, was performed on June 28th last, by the Lord Bishop of Rochester, in the presence of some one hundred visitors. On arriving at the Hospital, the guests, among whom we noticed Sir Henry Peek, Mr. Oswald Smith, Mr. Henry Hucks Gibbs, Rev. Professor Brown, and many others, were received by the Treasurer in the Governors' Court Room, and were then conducted to the Hostel. An address was given by the Bishop, in the course of which he expressed the pleasure it had afforded him to have been connected with the undertaking, and concluded by wishing every hope for its success. The address was followed by a few prayers, after which a vote of thanks to the Bishop, moved by the Treasurer, and seconded by Mr. Hucks Gibbs, was carried and suitably acknowledged. The guests next dispersed and viewed the building; every satisfaction and approbation being expressed at the excellence of the arrangements, a full account of which is given elsewhere.

Guy's Hospital Golf Club.

A COMMITTEE Meeting of the proposed Golf Club was held in the Smoking-room on the 5th inst. at 4.30 p.m., with Mr. Tubby in the chair. An offer from Norbury, to let an already-formed course, was brought before the notice of the Committee by Mr. Duncan, but the terms being considered too high, a Sub-Committee, consisting of Messrs. Tubby, Duncan, Hamlyn, Smith and Scott, was appointed to interview the owner and find out the lowest rent he was prepared to take. Letters were read from four hospitals, promising a total of 140 members in the event of the Club being formed; but this does not represent anything like the total that would join, as several large hospitals have not yet sent in the probable number of members, and those who have already promised members expect a considerable increase when the question of ground is settled. A Sub-Committee was also appointed to select a team to play a friendly game with Bart.'s. A ground for this match has been promised, and the match is expected to take place very soon.

A telegram from Mr. Purves was read, regretting his inability to attend, and suggesting that no final arrangement about a ground be made before consulting him.

Review.

"*The Physiology of the Carbohydrates.*" By F. W. Pavy, M.D., LL.D., F.R.S. London: J. & A. Churchill, 1894.

Since the discovery by Claude Bernard of glycogen, in the year 1857, no fact has had such a wide-reaching influence on research into the physiology of the carbohydrates as Pavy's discovery in 1861, that the production of sugar in the liver is a post-mortem phenomenon. Since that time, the author of the work before us, with true scientific enthusiasm, has continued his investigations into the fate of the carbohydrates in the body, and it is the record of these investigations that we have here presented to us.

After a brief account of the chief carbohydrates that are of importance for the animal economy, the author proceeds to describe the general changes which carbohydrates may undergo in living organisms, and draws an important contrast between the synthetic or dehydrating action of living protoplasm and the disintegrative or hydrolytic action of enzymes. The next chapter embodies Dr. Pavy's discovery of the glucoside action of proteid matter—a discovery which may have as great an influence on the physiology and pathology of the next forty years as the discovery of glycogen has had during the past forty years. According to the author, every proteid, whether derived from the blood, muscle, spleen or the white of egg, is a glucoside, and contains, intimately wrapped up in its molecule, a group closely allied to glycogen and starch, and which, on treatment with dilute acids, yields a reducing sugar. This fact is demonstrated in the following manner. The proteid, after having been coagulated by alcohol, and freed from sugar, is dried, pulverised and passed through a metallic gauze sieve. Of this dried powder, about two grammes are boiled in a flask, with the use of the inverted condenser, with 50 c.c. of a ten per cent. solution of potash, for half-an-hour. The contents of the flask are then poured into not less than 500 c.c. of methylated spirit, and the beaker is placed aside until the following day for the thorough settlement of the precipitate, which contains the starch-like constituent of the proteid. The precipitate is then collected on a glass-wool filter, washed with alcohol, dissolved in hot water, and, after the addition of sulphuric acid to the extent of two per cent., boiled for an hour and a half, or placed in the autoclave, and submitted for half-an-hour to 150°C. The solution is then neutralised with potash, made up to a known volume, filtered and finally titrated with the ammoniated cupric solution. In this way the amount of carbohydrate present in the proteid molecule could be estimated in the terms of dextrose. The following are some of the figures obtained:—

Egg-albumin	30	per 1000.
Proteid of blood serum	16	,,
Proteid of haricot bean	91	,,
Fibrin	22	,,

It is worth noting that casein only yielded a trace of reducing substance, and gelatin none at all.

The presence of a carbohydrate residue in mucin and in certain of the nucleo-albumins has been pointed out in recent years by various observers, such as Hammarsten, Landwehr and Kossel. The general applicability, however, of these results to all proteids, as demonstrated by Pavy, is a fact of such importance that we give here the various proofs brought forward by him of the identity of the body described by him. The precipitate which is thrown down by alcohol from the caustic potash solution forms in the dry state a hard resinoid mass, readily soluble in water, and giving no colouration with iodine. In its physical characters it resembles Landwehr's animal gum, and like this body, forms a copper compound on treatment with cupric sulphate and caustic potash. It possesses no reducing power on Fehling's solution, but acquires this power on boiling with dilute mineral acids. The reducing substance obtained by boiling with dilute mineral acids is soluble in water and spirit; it is readily diffusible, and gives Moore's and Trommer's tests for dextrose. With napthol and sulphuric acid it gives a colour reaction similar to that produced by sugar. With phenylhydrazine it yields a crystalline osazone. The osazone crystals melt at about 190°C. (Glucosazone melts at 205°C.). The substance is optically inactive and does not ferment.

It is evident that from proteids a substance can be extracted by fairly simple means, giving all the general reactions of a sugar, although the identity of the sugar cannot yet be established. Only one fact is wanting to remove the last shadow of doubt as to the carbohydrate nature of this body, and that is its preparation in a pure form in sufficiently large quantities to admit of an ultimate analysis.

It is interesting to note that the cleavage of the proteid molecule in digestion is associated with a splitting off of the reducing body, so that the end results of the gastric digestion of proteids are peptones and a reducing carbohydrate.

After a description of the analytical methods employed, including a comparison of the gravimetric method of estimating sugar with the volumetric analysis based on the use of the ammoniatedcupric solution, the author gives an account of the changes that take place in the carbohydrates after their ingestion. Of the new points mentioned in this chapter we may quote one interesting difference found to exist between the inverting power of the stomach and intestines in different animals. Thus, in most animals, such as the rabbit and dog, cane sugar is inverted by extracts of the mucous membrane of stomach and intestines. In ruminants, however, the intestinal mucous membrane is devoid of any inverting properties, whereas the ferment is found to exist plentifully in two of the stomachs, viz., those designated as the paunch and the manyplies.

It is impossible, in the brief space of a review, to do justice to, or even to enumerate, the many new facts which are presented to us in these pages. A few, however, which are of great importance for the history of carbohydrates in the body, may be summarised here:—

1. The blood of the general circulation contains from ·6 to 1·0 parts of sugar per thousand. This sugar is glucose.

2. The portal blood in digesting animals may contain from one to three parts sugar per thousand. This sugar contains some bodies of lower reducing power than glucose.

3. The liver during life and immediately after death only contains from one to two parts per thousand of glucose. After death this quantity rapidly increases owing to the fermentative conversion of glycogen.

4. The urine, in normal animals and in man, always contains small traces of sugar.

Dr. Pavy's researches lend no support to the view put forward by Bernard, and strongly upheld of late years (perhaps rather to its discredit) by Seegen, that the liver is a manufactory for sugar, and is always discharging sugar into the hepatic veins to be used up by the muscles and tissues. The function of the liver is, indeed, according to our author, the reverse of this, since it is always active in preventing the carbohydrates taken in with the food from escaping into the general circulation. If the liver is thrown out of gear, the blood at once gets loaded with sugar, which passes over into the urine, giving rise to glycosuria.

What then happens to the absorbed carbohydrates? It seems probable that they have a two-fold destiny. In the first place, they are built up to form part of the proteid molecules, being united with the peptone moiety of the digested proteids in the epithelial cells of the intestine.

In the second place, they are transformed into fat, a change which seems to occur even in the epithelial cells of the intestine itself. Photographs are given, showing the condition of the intestinal epithelium in rabbits before and after a meal containing a mere trace of fat (moistened oats). Although the food contained hardly any fat, the lacteals after the meal were found full of milky chyle, and the intestinal epithelium was crowded with fatty granules which stained a deep black with osmic acid.

We may sum up these results in the words of the last two sentences of the book. "By protoplasmic action carbohydrate matter, as observation teaches us, is disposed of in a certain manner. If not disposed of in this manner, it escapes from the system as useless material, producing the condition belonging to diabetes."

For the fuller development of the bearings of these physiological facts on diabetes, we must refer our readers to the work itself, trusting that the slight indication we have given of the general scope of the work may induce many to study it with the interest and profit which we have ourselves experienced.

Sport.

Cricket.

GUY'S v. FELSTED SCHOOL.

On June the 20th Guy's went down to play Felsted School. The visit was neither pleasant nor successful from our point of view, for, after waiting an hour at Bishop's Stortford on the way down, we lost the toss on our arrival and fielded while the boys made 139 for six wickets, to which Howell contributed an excellent 80. The rain then came down in torrents, and lasted till cricket was absolutely impracticable. For Guy's Barker took two wickets for 16 runs.

PAST v. PRESENT.

Played at Honor Oak on July the 3rd. This match was not as interesting as at one time it was hoped it would be, owing to many of the Past's best men disappointing Scott at the last. The Present gave the others, who were short, first innings. The Past put together 148, Cruikshank 24, Scott 25, and W. K. Steele 13 (not out), playing well, and Busteed making a lucky 27. For the Present, Palmer and Francis were the only ones who failed to obtain double figures. Hancock's 56 was slower than usual, while Pike's 40 was more energetic. Shorland, Nicholls, Alexander and Prince made it lively while they were at the wicket. Score:—

PAST.

J. H. Busteed, b Perks	27
S. G. Layman, b Nicholls	12
J. Cruickshank, b Nicholls	24
H. B. Bolus, b Pike	10
W. J. Scott, b Shorland	25
A. J. Carter, b Shorland	10
W. K. Steele, not out	13
D. Hancock, run out	0
F. Beard, b Shorland	7
H. W. Dudgeon, b Shorland	4
H. S. Desprez, b Shorland	3
Extras	13
Total	148

PRESENT.

A. Perks, b Layman	31
H. Palmer, b Layman	2
W. I. Hancock, c D. Hancock, b Cruickshank	56
C. J. Francis, b Layman	4
E. T. Shorland, run out	35
F. J. Nicholls, c Cruickshank, b Steele	31
K. B. Alexander, c Busteed, b Layman	24
N. H. Pike, c & b Layman	40
R. T. Fitzhugh, b Layman	14
P. C. Prince, b Cruickshank	29
H. Simson, not out	7
Extras	25
Total	298

GUY'S v. MIDDLESEX.

CUP TIE.

This semi-final was played at Forest Hill on June 29th, and for some little time was productive of great excitement. The ground man at Forest Hill had had short notice of the match, and there was so much grass on the wicket that it was hard to gauge whether it was good or not. Unluckily for us, Middlesex won the toss, and started on a wicket, which, it was soon evident, could not possibly improve. Baker and Mornement started very well, and were not parted till they had put on 75, Nicholls bowling the latter. Baker soon fell to the same bowler, and, with the exception of Berridge, the others offered very little resistance, the innings closing for 124. Nicholls, Shorland and Trouncer took four, three and three wickets for 36, 28 and 20 respectively. There were five available minutes for batting before lunch, and off the last ball in that time Perks lost his wicket by a weak stroke. Trouncer and Hancock put a better complexion on the game, and 50 was up when the former was bowled by Mornement. The wicket now had crumbled and was kicking badly, but matters looked fairly safe. Hancock and Nicholls then got out in quick succession, but not before the latter and Shorland had put on a few. Neither Francis nor Pike stayed long, and then when Alexander was playing a beautifully plucky game with him, Shorland was caught at the wicket—seven wickets for 116. The state of the ground caused doubts as to whether the last three wickets would realise the nine necessary runs, but Alexander and Fitzhugh stayed, and at 120 ran a quick run, which was made into 4 by two wild overthrows, and thus dispelled all anxiety. The last wicket but one then put on 37, and the innings closed for 172. Trouncer, Hancock and Ham all played well, and Shorland and Alexander both rose to the occasion when runs were most wanted. In the second innings Middlesex made 89 for six wickets.

Score:—

MIDDLESEX.

First Innings.		Second Innings.	
R. H. Mornement, b Nicholls	28	b Shorland	9
A. E. Baker, b Nicholls	46	b Hancock	6
E. K. Hewing, c Francis, b Trouncer	3	lbw, b Hancock	2
E. H. Berridge, c & b Nicholls	21	not out	40
C. Bascombe, b Nicholls	5	b Hancock	1
S. E. Tench, c Alexander, b Shorland	7		
F. Keats, b Shorland	5		
H. G. Ellery, c Alexander, b Trouncer	0	not out	18
M. E. Thomas, not out	1	c Trouncer, b Shorland	0
Langdon, b Shorland	0	c Nicholls, b Shorland	1
Hunt, b Trouncer	4		
Extras	4	Extras	10
Total	124	Total	89

GUY'S.	
C. A. Trouncer, b Mornement	18
A. Perks, c Langdon, b Mornement	7
W. I. Hancock, c Mornement, b Hunt	22
F. J. Nicholls, b Mornement	10
E. T. Shorland, c Tench, b Mornement	27
C. J. Francis, b Hunt	1
N. H. Pike, b Bascombe	9
K. B. Alexander, b Hunt	39
R. T. Fitzhugh, b Bascombe	4
B. B. Ham, run out	21
J. Moore, not out	0
Extras	14
Total	172.

Sporting Notes.

ATHLETICS.

The team selected to do duty for Guy's in the coming United Hospitals' Sports, to be held at Stamford Bridge on July 14th, is as follows:—

100 yards	H. T. Bell.	H. N. Collier.
220 yards	H. T. Bell.	H. N. Collier.
Quarter mile ...	F. S. Batchelor.	E. A. Longhurst.
Half mile	F. S. Batchelor.	R. Balderston.
One mile	H. A. Munro.	H. W. Dudgeon.
Three miles ...	H. A. Munro.	C. D. Edwards.
		P. F. Henry.
Hurdles	P. R. Lowe.	H. T. Bell.
Hammer	E. N. Scott.	
Shot	E. N. Scott.	R. S. Rowlands.
High Jump ...	H. T. Bell.	P. R. Lowe.
Long Jump ...	H. T. Bell.	H. N. Collier.

CRICKET.

At last the Final Cup Tie is upon us. Last week Guy's met and defeated Middlesex, on the Forest Hill Club ground, on a very bumpy wicket. We went down very confident of victory, but as events proved, there were some anxious moments. When only one of the Middlesex wickets was down for 75 runs, it looked like a day in the country for Guy's; subsequently, however, the Middlesex men could make no stand against our bowling, and were all out for 124. The Guy's Eleven entered on their task with a light heart, but thanks to some excellent bowling on the part of Mornement, with seven wickets down, Guy's still required some nine runs to win. We may with confidence assert that the Eleven has "no tail," or rather, that the tail is an excellent one, and wags to some purpose, as was shown in this match, for owing to some spirited hitting on the part of Alexander and Ham, Guy's qualified for the Final Tie by the substantial margin of 48 runs.

On Monday last St. Thomas's met and defeated St. Bartholomew's, on the Clubs' Union ground, at Honor Oak, after a very slow and monotonous afternoon's cricket. St. Thomas's ran up the tolerably good score of 230 before luncheon; Bart.'s men were jubilant at getting their opponents, who have the reputation of a strong batting team, out for what must be considered a moderate total, considering the fast wicket. Bart.'s started disastrously. Fernie and Bond put a better complexion on the game, the latter being third man out when the score had reached 70 odd. Fernie was fifth man out at 140 for a well played 49. Bart.'s again met with disaster, losing three more wickets without any addition to the score. The ninth man did not give much trouble, and then the game underwent a change, the last wicket causing the Thomas's men an increasingly anxious time until, at 195, all was over, something like 50 runs having been added since the fall of the ninth wicket. So we meet our old opponents on Monday and Tuesday next, on the Honor Oak C.C. ground; may the best side win, and may that be ours.

Appointments.

HIND, WHEELTON, M.D., B.S., F.R.C.S., has been appointed Medical Officer to the Workhouse of the Stoke-on-Trent Union.

KOETTLITZ, REGINALD, has been appointed Medical Officer to the Jackson-Harmsworth North Polar Expedition.

MACKERN, JOHN, M.D., Cantab., F.R.C.S., has been appointed Surgeon to the Miller Hospital and Royal Kent Dispensary, Greenwich.

Births.

BOLUS.—On June 21st, at Beckenham, the wife of Dr. Harry B. Bolus, of a daughter.

HOSKING.—On the 2nd July, at Warminster, the wife of John E. F. Hosking, of a son.

SHAW.—On July 1st, at St. Thomas's Street, the wife of Lauriston E. Shaw, M.D., of a son.

Marriages.

LONG—CLARKE.—On June 19th, at Duntesbourne Rous, Gloucestershire, by the Rev. D. Long, of Broadway, Dorset, and the Rev. F. A. Clarke, Rector of the Parish, David Sanderson Long, M.D. Cantab., to Isabel Dashwood, youngest daughter of the late Frederick Ricketts Clarke, Esq., of Taunton.

HODGSON—WOODFORD.—On June 20th, at Holy Trinity Church, Milton-next-Gravesend, Harold Hodgson, M.B., B.S. Lond., to Jessie, younger daughter of the late Henry Pack Woodford, of Gravesend.

Death.

TAYLOR.—On June 16th, at Clapham Road, S.W., David Taylor, M.R.C.S., L.S.A.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

JULY 21, 1894.

Three Cases of Oculomotor Paralysis.

CLINICAL LECTURE BY DR. NEWTON PITT.

CASE A.

ELIZA B., æt. 29. Failure of vision in the right eye last October; quite blind in both eyes in November. She gave birth to a child in February. Soon after there was ptosis of the right eyelid, paresis of the left arm, and to a less extent of the leg and face. An intensely tender area developed in the left parietal and supra-orbital regions.

When admitted, there was paralysis of the right third nerve, with paresis of the left; as shown by the eye looking out when at rest, and by the eye falling back to this position almost at once, if she attempted to look in, up, or down. Double optic atrophy. Mental feebleness. The patient has had four children, the first still-born, and another has died.

Diagnosis.—Cerebral tumour destroying right third nerve (? gumma), and involving right crus, and the left third nerve partially, and possibly the optic tracts. The reflected superficial pain is due to increased cranial tension.

CASE B.

Girl, æt. 2. Extreme rickets. Has never been able to stand. Mother has another child, æt. 3. No evidence of syphilis.

Four months ago there was ptosis of the right eyelid, which, after some time, cleared up again. There has been right external strabismus for two weeks.

For a week past there has been double ptosis; complete on the left side. The right eyelid can open a quarter of an inch. Double external strabismus, but very slight on left side. Right pupil rather dilated; insensitive to light; left pupil small, active.

Fundus of eyes normal. Phlyctenular ulceration of right eye. No headache. She has vomited once. Gradually, under Hyd. cum Creta, the ptosis on the left side disappeared, and that on the right became less marked. The external strabismus on the left side has also disappeared.

Diagnosis.—Possibly some early basal tuberculosis or inflammatory lesion; although often when internal muscles are affected differently from the external, the lesion is nuclear.

Paralysis of both third nerves may be due to—

1. Disease of nuclei.
2. Compression as nerves leave brain (syphilis or tubercle).
3. Compression outside, due to basilar meningitis.
4. Pressure from dilated posterior cerebral arteries (Türck, Nothnagel).

CASE C.

Sarah W., æt. 37. A year ago failure of sight in the right eye; at Christmas left hemiparesis. Latterly attacks of pain with rigidity in her neck. Now she has paresis of left third nerve, optic atrophy in the right eye, with very slight early atrophy in left. Slight weakness in the left arm; none in the legs. Knee-jerks and reflexes normal. Sensation normal.

June 5. There is loss of vision over the right half, and defective over the rest of the field in the right eye; vision in left eye normal; pupils dilated. When light is thrown on the right eye, it fails to contract; when thrown on the left, it barely reacts, but the right contracts vigorously.

Diagnosis.—Optic atrophy, especially right side; left hemiparesis, paralysis left third nerve. Probably a basal lesion.

The pupil can react to—

1. Accommodation.
2. Convergence.
3. Light falling on the retina.
4. Light falling on the opposite retina.
5. Tickling, or a painful cutaneous stimulus.

The reflex arc for (3) is optic nerve, tract, anterior part corpora quadrigemina; third nerve, ciliary ganglion and ciliary nerves.

The right eye failed to contract on account of the right optic atrophy, and the left on account of the paralysis of the left third nerve; but the consensual reflex to light remained, as the required path (left optic nerve and tract, both anterior corpora quadrigemina, right third and ciliary nerves) was intact.

The centre for accommodation is the most anterior part of the third nucleus, lying in the floor of the third ventricle. Behind this is centre for the iris, and close to it that of the internal rectus. The centres for left levator palpebræ, superior rectus and inferior oblique are in the outer part of the nucleus.

The nuclei for iris movements are supplied by posterior communicating artery; the nuclei for the external muscles, innervated by the third nerve, are supplied by the superior cerebellar artery. The pulvinar, in the

lateral wall of the third ventricle, disease of which will cause optic atrophy, is supplied by the posterior cerebral artery.

Optic neuritis is against nuclear disease; preservation of the internal muscles intact is in favour of it.

In cases of ocular paralysis, we can generally determine which muscles are affected; but it is most difficult to determine whether the lesion is nuclear or peripheral, and often it may be impossible to state accurately the cause of the lesion; this would appear to be the case in both B and C.

The various lesions to be considered may be classified as follows:—

Nuclear.
- Degenerative.
  - Syphilis, tabes, insular sclerosis.
  - Progressive muscular atrophy.
- Tumour.
- Pressure effects.
- Hæmorrhage.
- Softening.
- Maldevelopment.
- Polioencephalitis (allied to infantile paralysis).
- Diphtheria (?).

Crus.
- Tumour.
- Softening.
- Hæmorrhage.

Meningitis.
- Tuberculous.
- Gummatous.
- Inflammatory.

Peripheral.
- *Toxic* as diphtheria, diabetes, alcohol, etc.
- Gummata.
- Inflammatory.
- Pressure.
- Exposure to cold, "so called rheumatic."

The determination of which ocular muscle is paralysed, and the positions of the false images with the various paralyses, may be much simplified by the following considerations:—

1. The axes about which the muscles move the eyeball are fixed with regard to the orbit, and do not vary as the eye moves.

2. These axes, which run through the centre of the eye, are for—

Internal and External Recti.—A vertical line.

Inferior and Superior Recti.—A line parallel to one through the bridge of the nose and the external angular process.

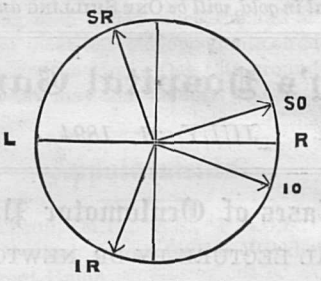
Inferior and Superior Oblique.—A horizontal line parallel to one drawn just outside cornea to just inside optic disc when eye is looking straight forwards.

3. If there is diplopia when the patient looks up, the *upper* image is the false one, and there is paralysis of either a superior rectus or an inferior oblique; if when he looks *down*, the *lower*; and there is paralysis of a depressor.

4. The superior and inferior recti are adductors, the diplopia, when they are paralysed, is therefore crossed. When the eye is adducted, they act as rotators; when abducted, as elevators or depressors.

5. The oblique muscles are abductors, the diplopia is therefore homonymous. When the eye is adducted, they elevate or depress; when abducted, they rotate.

6. The following diagram, suggested by Mr. W. L. Braddon in this GAZETTE in 1887, may assist in remembering the displacements of the images of a stick placed vertically in front when one of the muscles moving the *right* eye is paralysed.



This diagram, which indicates the movement of the pupil by each muscle, also gives the position of the false images as seen by the patient.

If the right superior oblique be paralysed, the false image present by (3) when he looks down is displaced downwards, and to the right with the lower end tilted to the right. By (5), when the patient looks to the right, the false image is much tilted; when to the left, it is depressed.

Again, suppose the false image occur in upper part of field, and lie to the left, above and tilted to the left of the true image. If this image is red when a red glass is over the right eye, the diplopia is crossed; the affected muscle is one which elevates and abducts. It is, therefore, the right superior rectus and the displacement also agrees with diagram.

Difficulties arise chiefly when secondary contractions have taken place after some months in the healthy unopposed muscles, and also when the paralysis is only partial and the patient is able to more or less overcome the defect by exerting himself when the displacements vary with each observation.

Appointments.

BRYANT, H. A., L.R.C.P. Lond., M.R.C.S. Eng., has been appointed House-Surgeon to the Durham County Hospital.

GRANGER, EDGAR B., L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Medical Officer for the Great and Little Milton Districts of the Thame Union.

Congenital Funicular Hernia of Cæcum.

CLINICAL LECTURE BY MR. DUNN.

(From Notes by Mr. C. H. FAGGE).

THE subject of my lecture to-day is well illustrated by the case of the boy we have before us, and as I shall not require him long, I will first of all go over the points of interest in his case, and then make some general remarks on the subject, so that our patient may return to the Ward. You will see he is a small, delicate-looking child, of four years of age, whom the report says was admitted into Martha, under my care, on May 22nd, for a swollen scrotum. This swelling had existed since birth; about two and a half years ago the friends returned it to his abdomen, but this was the only time this has been done, and since then it has been continually down, and has never given patient any trouble. Now, we noticed on examination that on the right side of the scrotum was a large swelling, at the bottom of which the testicle could be felt. The swelling itself gave an impulse when patient cried; was not translucent; was expansile; gurgled on pressure; was not reducible on taxis; it is regular in outline, doughy in consistency, and somewhat nodular to the touch. On further manipulation, a round, hard, worm-like body could be felt, which I considered to be the vermiform appendix, which had descended into the scrotum with a cæcal hernia. The position of the left testis is normal. The child was kept in and fed up for a fortnight, so that his general condition might be improved before the operation.

Now, I have, as you may have noticed, called this hernia congenital, but it cannot be strictly said to come under the heading of the congenital herniæ, and the chief point which tells us that this is so, is the position of the testis in our case. Your knowledge of anatomy tells you that in a true congenital hernia the loop of intestine, passing down through the still-patent neck which connects the tunica vaginalis of the testis with the general peritoneal cavity, comes to lie first of all above, then in front of, and finally below the testis. In our case, which is really of the funicular variety, the neck spoken of above has at the lower part closed up, and so no longer affords a passage for the hernial loop into the tunica vaginalis, and as a result of this the intestine must lie above the testis altogether.

You remember that I said the hernia was irreducible. In order to attempt to reduce it, I grasped the external abdominal ring with the thumb and index finger of my left hand, and taking the swollen right side of the scrotum in the right hand, I gently and uniformly squeezed it in my attempts to pass it up through the space between my left thumb and index finger, and so along the inguinal canal into the abdominal cavity—but my attempts in that direction failed.

A hernia such as this one very often contains omentum, and this will lie in front of any loop of intestine which may be present; again, this omentum may be the cause of such a hernia being irreducible, and I will here note the chief causes of such a condition.

1. The omentum may become more infiltrated with fat, and so be too large to be passed back through the orifice down which it has come.

2. The intestine, which is in some cases present, may receive obstructing bodies such as cherry stones, which prevent its return.

3. Adhesions may form (*a*) between the hernial mass and the sac; (*b*) between the various parts of the hernia, as between a piece of intestine and omentum.

4. Again, the hernia may be irreducible on account of its "nature"—for some hernia which are said to possess no sac come under this heading—these are:—

a. A cæcal hernia.

b. Hernia of bladder.

With regard to the latter form of hernia, great care must be exercised in its diagnosis; for when mistaken, it is most fatal, and so will do you a great amount of harm.

I will only here mention one case of hernia of the bladder which I remember. In this, hernia having been diagnosed, the skin and the various other layers were divided, and at length, one of the inner layers was exposed, and said to be the hernial sac—this looked smooth on the outside—and was, when incised, found to contain no viscus, although some yellow fluid, like serum, came away. Well, the surgeon thought that the viscus had been reduced into the abdomen, so what was supposed to be the sac, was ligatured at its neck and cut off, and presently the patient died, and at the post-mortem the bladder was found to have been cut away for sac. Now, this mistake ought not to occur, for peritoneal sac and bladder should be distinguished by the three following tests:—

1. The muscularity of the supposed sac should point definitely to bladder, as, of course, there will be no muscular fibres on the peritoneum.

2. The mucous membrane would be most unlike the smooth peritoneum; to notice this, the bladder must have been opened, but of course there is still time to sew it up and return it into the abdomen.

3. If the bladder has been opened by mistake, the cut surface will bleed and look red, which will not be the case with the peritoneal sac.

With regard to what I have said about the "nature" of cæcal hernia, which is the cause of its irreducibility, I think this is not exactly the truth. The specimen from the museum before us, shows us a cæcal hernia just like that in the patient I have shown you, which was reducible; and even in our case, as the report notes, the hernia was at one time reducible and afterwards became fixed—the cause of which was shown by the operation to be adhesions due to tubercle and an inflammatory patch at the apex of the vermiform appendix. So you will readily understand that cæcal hernia may be reducible.

Other causes of irreducibility are:—

5. A large outpouring of fluid into the sac—and this we cannot look upon as altogether a nuisance—in fact, for some reasons it is a very excellent natural process,

as it forms a water bed and safeguard for the loop of intestine to prevent it being injured by forcible taxis.

6. The narrowing of the abdominal ring.

As regards treatment of hernia. This may be palliative, such as rest in bed, the application of an icebag, which helps to contract the dartos and limits the blood-supply to the part. Grey powder may be given at the same time; another method is the use of a "moulded" truss, made of indiarubber, by means of which firm yet gentle pressure is applied, so that the hernia is prevented from being increased in size, and yet is not so nipped as to cause gangrene.

These, however, are now regarded as rather archaic measures, and the best treatment by far is operation—the radical cure—and what you do is this. The part must be carefully shaved, if necessary, and rendered aseptic, when an incision is made in the long axis of the swelling, and following on this the deeper layers are cut through as they are recognized, which may be a process of some difficulty if the adhesions are extensive. The sac, when it is reached, may be known by its blueish white colour, it is also rather shiny and covered with fat; in order to make quite certain that it is sac and not gut, its wall may be pinched up in the finger and thumb when the gut beneath, if present, will slip away.

In the case I have described to you, the sac was very adherent and inside was the cæcum, vermiform appendix and several coils of collapsed intestine: the intestine was returned, and the cæcum when separated from the surrounding tissues was also reduced.

The separation of the sac is often attended with some difficulty, as it is surrounded by the constituents of the cord; but the best way to tackle it is from above, and that is the place I advise you to begin unravelling it. You should then ligature the neck of the sac with some chromicised gut and stitch up the external abdominal ring.

The two ends of the ligature controlling the sac should not be cut off, but should be carried up the inguinal canal and out near the internal ring through the abdominal wall at a little distance from one another. The two ends may then be tied, and others should be inserted in the same way below this and crossed and tied—much in the way that a lace boot is done up, except that the crossing must take place on, and not between, the edges of the wound, so as to ensure complete apposition.

Well, this is what we did with our patient and he was very bad during the operation, so bad in fact that we had to inject a good deal of brandy from time to time. His weakness and ill health were against us, and you often see patients become seriously affected by the manipulation of the intestines and the cord, which is no doubt due to solar stimulation. The wound was dressed with iodoform and single layers of blue gauze, placed on one another so that each quite overlapped the one beneath it; each layer was carefully sealed down with collodion, and so we had a completely sealed up dressing, which was completed by some wool and a spica bandage. I have found these sealed dressings most useful in herniæ, especially of children, as there is great risk, in using the ordinary method, of the patient wetting them or pulling them about. On the seventh day the stitches were removed and the wound dressed with blue gauze, and the boy has since done very well.

You will notice that in the above case I did not follow my usual mode of procedure in removing the vermiform appendix, which I do for the following reasons:

1. To remove a dangerous and useless part of the alimentary canal.

2. The slight inflammation consequent on its removal, *i.e.*, around the cut surfaces, tends to promote adhesions which act as an anchor to the cæcum, and prevent it again moving about the abdomen.

The details of this part of the operation are, first cut through the peritoneum, as near the inflamed apex as possible, and roll it back on the proximal portion of the appendix, as you would a finger of a glove in which the end had been removed; now cut through the appendix, *i.e.*, muscular and mucous coats near the root, and turn them inwards and sew the orifice up: then around this turn in the peritoneum, so that the outer surface is in apposition at all points, and sew this together with a Glover's stitch.

Before I make my concluding general remarks on cæcal hernia, I will briefly recall to your notice two cases I had under me on previous occasions.

R. P., a boy of two years, was admitted under me in October, 1890, for rupture on both sides, which had existed since birth. He had worn a truss since he was seven months old, which had kept the hernia up until the previous July; at that date he had whooping cough and nothing had kept up the hernia since then. He had never been a strong child. Family history good.

On admission, he had a double inguinal hernia, which formed a scrotal tumour the size of a small cocoanut. That on the right side was irreducible. At the operation, I cut down upon and opened the sac, which contained the cæcum and vermiform appendix—the latter being adherent to the testis. I then removed the vermiform appendix in the way I described above and reduced the hernia, when the sac was dissected out and ligatured and the rings closed. The wound was dressed with gauze but became septic by being fouled with urine, and so suppurated. Patient also developed measles, which prolonged his recovery. However, he was discharged in January, cured.

W. J. B., another boy, aged 16 months, was admitted under me in April, 1892, for right-sided rupture, which has been present since birth. The condition has been aggravated by bronchitis. On examination, there is on the right side an inguinal hernia the size of a Tangerine orange when the child runs about. On lying down the mass is quite reducible, and no omentum is felt in the sac.

The hernia is funicular, and the testis is below it. On careful palpation, a worm-like body is distinguished, the free end of which can be felt, and the other can be

traced to the gut. The external ring is wide, and admits easily the tip of the index finger; the canal is short and dilated, and the internal ring can be distinctly felt. Radical cure performed, as in the other case, and patient went out cured in three weeks.

As in the cases I have brought before you, cæcal hernia generally occurs on the right side; but one case of left inguinal hernia is recorded in which the cæcum was found in the sac.

The points in the diagnosis of it are:—

1. Usually right-sided.
2. The tumour is always large.
3. Generally irreducible.
4. The appendix can often be distinguished by its worm-like outline.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

PHILIP	23.	Aortic stenosis. Ulcerated leg.
	27.	Mitral stenosis.
	30.	Mitral stenosis and regurgitation.
	32.	Angina Pectoris.
	37.	Dilated right ventricle.
STEPHEN	5.	Aortic stenosis and mitral regurgitation.
	16, 18.	Mitral regurgitation.
	19.	Mitral stenosis. Embolism; left hemiplegia.
	20.	Mitral stenosis. Bronchitis.
	33.	Mitral stenosis and regurgitation.

Nervous System.

PHILIP	16.	? Cerebral syphilis.
	25.	Celebral tumour. Trephining.
	28.	Fits. ? Epilepsy.
	35.	Optic neuritis.
STEPHEN	12.	Cerebral tumour.
	30, 17, 24.	Myelitis.
	21.	Locomotor ataxy.
	22.	Right hemiplegia. Cerebral hæmorrhage.
	25.	Diphtheritic Paralysis.
MARY	14.	Hysteria.
	19.	Chorea.
	36, 26.	Post diphtheritic Paralysis.
	42.	Myelitis.

Respiratory System.

PHILIP	18.	Acute tuberculosis. Cerebral tumour.
	38.	Left pleurisy.
STEPHEN	4.	Pleuritic effusion.
	13.	Broncho-pneumonia.

Phthisis.

PHILIP	7, 10, 13, 15, 21, 29.
STEPHEN	11, 31.
MARY	37, 31, 41, 45, 48.

Genito-Urinary System.

PHILIP	5, 8.	Chronic nephritis.
	19.	Diabetes.
	20.	? Renal calculus.
	40.	Chronic nephritis.
	14.	Tuberculous kidney.
	15.	Diabetes.
STEPHEN	23.	Acute nephritis.
	40.	Chronic nephritis.
MARY	2.	Movable kidney.
	4.	Chronic nephritis.
	10.	Diabetes.
	21, 31.	Movable kidney.
	44.	Diabetes.

Alimentary System.

PHILIP	17.	Carcinoma of pylorus.
	34.	Tuberculous peritonitis.
STEPHEN	6.	Tuberculous peritonitis.
	27.	Appendicitis.
	39.	Carcinoma of pylorus.
MARY	3.	Appendicitis.
	6.	Abscess about gall-bladder.
	20.	Jaundice. Gall-stones.
	38.	Carcinoma of pylorus.
	49.	Dilated stomach.
	50.	Tuberculous peritonitis.

Miscellaneous.

PHILIP	2.	? Tuberculosis. ? Lymphadenoma.
	4.	? Tuberculous knee-joint. ? Chronic rheumatism.
	6.	Osteo-arthritis.
	11.	Plumbism.
	12.	Enlarged spleen. Ague-cake.
	31, 33.	Gout.
	36.	Tuberculous ulceration of skin.
STEPHEN	2.	? Hodgkin's disease.
	7.	Gout. Hypertrophied heart. Mitral regurgitation.
	26.	Chronic nephritis.
	27.	Hodgkin's disease.
	39.	Osteo-arthritis.

Acute Rheumatism.

PHILIP	26.
STEPHEN	38.
MARY	12, 25, 34, 35.

CASES UNDER DR. PYE-SMITH.

PHILIP.

26. J. G., æt. 18. Admitted on July 10th for swelling and eruption of legs. Family history is fairly good.

Previous history.—Patient has been twice in the Hospital for acute rheumatism, both times in 1889; otherwise he has been healthy.

Present illness.—Patient injured his knee on June 27th. A few days later it became swollen and painful. The rash appeared on July 5th.

On admission.—There are crusts on patient's right cheek, forehead and nose; several papules and pustules on face and neck. The left knee was swollen and rather painful. About both knees there was an eruption of pustules and vesicles. The fluid in some vesicles was semi-purulent.

Heart.—Impulse in sixth space, three-quarters of an inch internal to nipple line. At the apex can be heard

a presystolic and a systolic bruit, the latter of which can be heard in axilla.

July 13th. Crusts have formed on left knee, and also on scalp; occipital glands enlarged and painful. Presystolic bruit has changed to a mid-diastolic. Ung. Hydrarg. Ammon. cum Plumbo was applied to rash.

16th. Crusts are separating and leaving the part beneath red. Several more pustules have appeared on his arms and chest. Patient's temperature has not been above 101, and is now normal.

Dr. Pye-Smith's diagnosis was mitral stenosis and regurgitation. He considered the skin lesion of face and head to be impetigo, probably of traumatic origin; that on the knees, Miliaria.

28. W. L., æt. 41., a brewer's labourer. Admitted on July 6th for cough and dyspnœa, with old right paresis and twitching of thumb.

Family history.—A maternal uncle died during a fit, the nature of which is not known.

Personal medical history.—Patient in his 13th and 14th years had fits, which began by twitchings in his thumb and fingers, then hand, forearm, arm, and ended by patient becoming unconscious. Subsequently he had attacks which were accompanied by severe headache (vertex), but did not become unconscious. He has had several attacks of cough and dyspnœa. There is no history of syphilis or alcoholism.

Present condition.—Respiratory: Deep chest, with wide epigastric angle, hyper-resonant, cardiac dulness diminished; loud expiratory and inspiratory rhonchi. *Nervous:* there is twitching of the facial muscles, especially frontalis. The tongue is tremulous when protruded. No facial paralysis. Tremor of the right thumb and left index and forefingers, increasing when arms are extended. There is partial loss of power in right arm, and considerable wasting. There is no loss of sensation, of touch, or heat and cold. Plantar reflex is increased on the right side. There are no exaggerated knee-jerks. *Urine* 1020, normal. *Eyes* normal, equal; react to light. There is some ataxy in upper extremities.

Dr. Pye-Smith diagnosed bronchitis with emphysema. The paresis and twitching following eclampsia.

Case under Dr. Goodhart.

Philip.

12. I. W., æt. 38. Admitted for pain in the left side of abdomen. Patient had dysentery four years ago. Enteric fever last June when in India. Malaria, nine attacks, the last in July, 1893. In October he had an abscess in the liver, a quart of pus being drawn off.

On admission.—The abdomen is distended; the right side moves better than the left on respiration. The spleen reaches two inches to the right of the umbilicus and four inches below. ? Ague-cake.

Blood.—89 per cent. of red corpuscles; no white seen in the field examined. Hæmoglobin 90 per cent.

Eyes.—Black pigmented streaks were seen on the lower part of the choroid of both eyes.

Cases under Dr. Hale White.

Mary.

7. E. M., æt. 33. Admitted May 31st for pain in right side of abdomen.

Family history.—Mother died of phthisis; father alcoholic; brothers and sisters all healthy. Patient is married and has four children.

Previous history.—Patient has suffered from bronchitis and asthma for some years; has never had acute rheumatism nor any acute fever. She has never resided out of England, and has not lived in a marshy district. She has always been temperate.

Present illness.—In June, 1893, when patient was six months pregnant, she had pain in right hypochondrium, about half-an-hour after food, accompanied by flatulence; pain did not go through to back; this lasted for a month. After the confinement in September, similar symptoms reappeared. The doctor in attendance discovered at this time that the liver was enlarged, and at the lower edge and in neighbourhood of gall-bladder was a swelling which was resonant; patient was *slightly jaundiced.* In October, Dr. Shaw saw her at out-patients, and diagnosed obstruction of cystic duct with distended gall-bladder; patient did not come into the Hospital. Soon afterwards, swelling disappeared; motions were not examined for gall-stones. There was no fresh attack of pain until two months ago, when she was suddenly seized with acute pain in the right side which quite "doubled her up"; this lasted for twenty-four hours, during which time rigors occurred. She soon became jaundiced and the urine was dark in colour. Since that time she has felt very unwell, being unable to get about, and pain of a dull character has been constantly present.

On admission.—Patient is anæmic, and has a pale yellow-looking skin; conjunctivæ not yellow; pain and tenderness present over area of gall-bladder; liver enlarged, dulness commencing at sixth rib, and extending downwards for four inches in nipple line, whilst edge can be felt an inch still lower; no actual swelling of gall-bladder can be felt; spleen is uniformly enlarged, extending down as far as level of anterior superior spine; splenic dulness also increased in an upward direction; at level of umbilicus, anterior edge is two inches from umbilicus; no tenderness over this area. No ascites. Patient has a poor appetite, and is constipated.

Heart.—Impulse in fourth space, one inch internal to nipple line. Soft blowing systolic murmur at apex, traceable outwards for a short distance.

Lungs.—Normal.

Urine.—Acid, 1020; *no albumen;* bile pigment present.

Ophthalmoscope.—Eyes normal.

Blood.—Red corpuscles 80 per cent.; hæmoglobin 65 per cent.; no increase in white corpuscles.

Temperature normal. No enlargement of glands. No tenderness of bones.

Dr. Hale White considered that the history showed the case to be one of gall-stones, but the continuance of pains after the attack of biliary colic was peculiar, and

suggested an impaction of a stone in the cystic duct, though against this was the absence of any appreciable distension of the gall-bladder. The enlargement of the liver could be explained as dependent on presence of gall-stones, but the spleen could not be similarly accounted for; the enlargement might be due to congestion, but it was very improbable. The various conditions which would produce such an enlargement of the spleen were discussed, but most were rejected. Only the following need be mentioned:—

Cirrhosis.—No alcoholic history.

Ague-cake.—No history of ague.

Hodgkin's disease.—No enlargement of glands.

Leuchæmia.—No increase of white corpuscles. Eyes normal.

Lardaceous.—No albumen. No suppuration nor syphilis.

Infarction.—Systolic bruit probably functional. No tenderness of spleen. Temperature normal.

Splenic anæmia.—A very rare condition.

Since admission patient has had no further attack of biliary colic, though she continually suffers from the lingering dull pain in right side of abdomen. Patient is anxious to have an operation performed. It was pointed out to her that the enlargement of the spleen made her a bad subject, and probable impaction of the gall-stone would possibly render the operation severe; however, as she can do nothing in her present condition, she decided to undergo an operation. Bile pigment has disappeared from urine. Spleen and liver are unaltered. No stones have been observed in the motions.

Operation.—June 19th. Mr. Dunn made a vertical incision, three and a half to four inches long, in right linea semilunaris; rectus muscle was broad and had to be divided in line of incision; peritoneum was exposed and opened; a number of adhesions were found round fundus of gall-bladder, which were separated and divided between ligatures; the fingers were next introduced into wound and a hard mass felt; this was brought into view and was seen to be the gall-bladder, the walls of which were obviously thickened. Iodoform gauze was next packed in wound and other viscera kept out of the way. An exploratory puncture was then made into the gall-bladder and some thick pus was drawn off. Two sutures were then put through gall-bladder, which was incised, mucus and bile being found, but there was no further escape of pus; no stone could be felt with either director or probe; edges of gall-bladder were then sewn to parietes and a plug of iodoform gauze inserted. A deep suture was put in lower part of wound, and upper and lower limits were approximated by superficial sutures.

Microscopical examination of pus showed presence of pus cells and a few red blood corpuscles; no cholesterin crystals were found.

20th. Patient passed a very good night. Pulse 96; temperature 98·6. Wound dressed; dressings soaked through with mucus and a little bile; no pus. Plug of gauze removed and a drainage-tube inserted.

24th. Patient doing very well; no rise of temperature, and pulse good.

25th. An anæsthetic was given and a further exploration made for gall-stones; large and small probes were passed, but nothing resembling a gall-stone could be detected. Just above the gall-bladder a small abscess was discovered and opened up, about ʒss. of pus being drawn off.

26th. Patient was only sick once after the operation; had a good night and is now free from pain. Patient was dressed this morning, old dressings being soaked with bile. Mr. Dunn thinks that the localised abscess was pressing on the duct, and so produced the pain and tenderness in that region.

30th. Patient continues to do well, and is on ul diet; there is no pain, and wound is going on favourably.

July 7th. Discharge from wound, mucus and bile. Wound healing. Patient gets up on couch in evening.

16th. Patient still improving.

Blood.—Hæmoglobin, 50 per cent.; corpuscles, 98 per cent.

Spleen.—Unaltered apparently.

19th. Patient doing well; has been up and about some time. No pain since operation. No jaundice. Spleen and blood as before operation. Dr. Hale White thinks that almost the only suggestion possible is that she has splenic anæmia, independent of the trouble about the gall-bladder, which was, perhaps, set up by a gall-stone.

STEPHEN.

32. P. T., æt. 26, a soldier, was admitted on June 27th, for flatulence and general debility.

Family history.—Unimportant.

Personal history.—Lived in England until 1887, and was healthy; weight 11 stone. He then went to India, and after dysentery 12 months ago, returned in November last. He appears to have recovered from his illness.

History of present illness.—After dysentery, he noticed his abdomen to be swollen; became weak, lost his appetite, and frequently vomited—usually about two hours after meals; the vomit consisted of partially digested food. Patient had a slight cough, but no expectoration; he wasted and became pale. His bowels have been regular, and he has since remained in much the same condition, except that he has not vomited during the last few weeks.

On admission.—Patient has an anxious expression; is thin; weight 6 stone 5 lbs.; seems eager to impress one that he has never indulged in alcohol nor contracted any venereal trouble. Besides some general distension of the abdomen, there is marked bulging at the upper part on the right; the whole is resonant to percussion, except for dulness in the extreme flanks; this dulness does not alter with patient's position. There is no thrill. In the right flank, on percussion just below the ribs, there is a high-pitched tympanitic note, which extends as high as the ninth rib. The note over the upper part of the abdomen in front is low-pitched and tympanitic, and is continued up on the right side as high as the sixth rib

in the nipple line, above which there is dulness up to the fourth rib. The same note can be obtained on the left side in the axillary line as high as the fourth rib. No succussion of stomach contents could be obtained.

Lungs.—In front, on the left side, fine crepitations can be heard in the second space on deep inspiration. Behind, resonance is impaired on both sides below the eighth rib; air does not enter well at the bases. About one inch below, and outside the nipple, there is a tender spot.

Heart.—Impulse in the third space, just to the left of the sternum; it is also visible in the second space. Dulness begins about at the third rib, and extends to the left, as far as the left border of the sternum. Sounds faint; no bruits.

Urine.—Sp. gr., 1009. No albumen nor sugar. Indican present.

Blood.—Red corpuscles, 85 per cent.; white not increased.

June 29th. Patient's chest was explored to-day on the right side in the ninth space, and in the tenth space on the left; only a little blood came away.

30th. Patient vomited up half a porringer of semi-digested food, and eructated a quantity of wind after it.

July 2nd. The tympanitic area has altered, and now does not quite reach the costal margin on the right side. About this level liver dulness is perceptible.

3rd. The tender spot has disappeared. Patient gets up after tea. Diet full.

℞ Tinct. Nuc. Vom. ... ... ℥v.
Mist. Acid Co. ... ... ad ℥xii.

9th. Abdomen less distended; appetite good. Patient gets up all day.

15th. Patient was sick five times to-day, for which he is taking:—

Pil. Acidi Carbol. ... ... gr. v., t.d.s.p.c.
Troch. Sodii Bicarb. ... ... ij. s.o.s.

16th. Patient stronger; abdomen rather more distended. The tympanitic area is now bilaterally symmetrical, crossing the sternum at the sixth chondro-sternal articulation, the seventh rib in the nipple line and leaving the thorax at the ninth costal cartilage.

Patient sick to-day, once during the morning.

17th. Patient very sick again, immediately after dinner.

18th. Patient looks pale, and his lips are rather yellow. His hands are rather cold. He went out to-day at his own wish.

Dr. Hale White regarded this case as being one of chronic loss of tone of the muscular gastro-intestinal wall, causing a dilatation of the stomach and intestine, following on an attack of dysentery. He thought good food and healthy exercise, provided not excessive, and Nux Vomica, the proper treatment.

When the patient came in, the extension of the tympanitic note into the left axilla was due to distension of stomach with gas. As there was no excess of fluid in it, the other well-known signs of gastric dilatation were not attainable. The faintness of the cardiac sounds, and the absence of the impulse from the usual position, were due to the same cause. The alteration of the hepatic dulness from normal to an area between the fourth and sixth ribs in the nipple line, was due to the distension of stomach, or stomach and intestine, either pushing back the lower edge of the liver, or giving a resonant note through a thin lower edge of it. The pushing up of the liver explained the fact that the hepatic dulness reached the fourth rib. The correctness of the diagnosis was proved by the shifting of the tympanitic areas from day to day, and by the improvement of the patient. The bases of both pleural cavities were explored, because it was just possible, as he had been abroad, there were deep-seated hydatids giving dulness behind, but the absence of fluid showed that, as was thought, the dulness was due to compression of lung from gastro-intestinal distension.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	8.	Enlargement of testicle. Improvement under treatment with Pot. Iod. ? Syphilitic.
	10.	Enlarged prostate. Retention of urine.
	7.	Gonorrhœa. Congestive stricture.
	14.	Large ilio-psoas abscess. Origin uncertain.
	13.	Ankylosis of ankle. Exploration. Ankle-joint found firmly ankylosed. Also astragalo-calcaneal joint. ? Tubercular.
	3.	Old ununited fracture of femur. Screwed fragments. Failure to unite. Amputation.
	6.	Inguinal hernia.
Charity	8.	Hip-disease. Interstitial keratitis. Congenital syphilis.
	12 & 20.	Two cases of compound depressed fracture of skull, affecting arm centre on right side, leading to paralysis of left arm. Trephining.
	10.	Severe laceration of scalp.
Charity	13.	Intra-capsular fracture of neck of femur.
	Cot.	Old scald of fingers. Webbing of fingers has resulted.
	Cot.	Congenital talipes equino-varus. Previously operated upon by division of all soft structures down to bone on inner side of sole of foot. Return of deformity in one foot, owing to neglect. Complete division of structures again performed.
	Cot.	Congenital cystic swelling of neck.

Cases under Mr. Davies-Colley.

Luke	5.	Symptoms of intestinal obstruction. Inguinal hernia, apparently not the cause. Laparotomy. Matting of intestine. Perforation of bowel above constriction. Suture of bowel, etc.
	8.	Farrier. Pustule on lip. Marked œdema of side of face.
	19.	Abscess over tendo Achillis.
	8.	Varicose veins of leg.

LUKE	10.	Enlarged prostate. Retention.
	4.	Compressive paraplegia. ? Caries of spine.
	9.	Varicocele, left.
	17.	Congenital inguinal hernia. Admitted for radical cure.
	20.	Tubercular caries of rib.
CORNELIUS	12.	T-shaped fracture into knee-joint.
	15.	Fracture through upper epiphysis of humerus.
LYDIA	23.	Abscess over mastoid process. History of otorrhœa. None on admission. Pediculi capitis with eczematous patches on scalp. Abscess, which closely simulated abscess due to mastoid disease, apparently dependent on condition of scalp.
	20.	Old fractured jaw. Necrosis.
	9.	Congenital talipes equino-varus.
	Cot.	Hare-lip and cleft palate.
	7.	Painful subcutaneous tumour.
	6.	Tumour of breast.
	17.	Old erosion of knee; subsequent ankylosis in flexed position.
	Cot.	Syphilitic disease of hip and knee-joints.
	8.	Rodent ulcer of face.

CASES UNDER MR. LUCAS.

JOB	—.	Three cases of mastoid abscess, subsequent to middle ear disease. Antrectomy.
	9.	Enlarged prostate.
LYDIA	13.	Sarcoma of glands of neck.

CASES UNDER MR. GOLDING-BIRD.

MARTHA	21.	Pain over sacro-iliac joint, etc. ? Sacro-iliac disease.
	1.	Swelling in neighbourhood of umbilicus; taken to be an umbilical hernia. Exploratory laparotomy. Dermoid removed from abdominal cavity.
	20.	Rheumatoid arthritis. Injury to hip. ? Fractured femur.
	18.	Appendicitis. Operation.
	18.	Fibrous epulis.
	5.	Hæmorrhoids. Retroverted uterus.
LAZARUS	16.	Wound of penis.
	22.	Inflammatory swelling behind inner ankle. ? Tubercular disease of os calcis; or tubercular disease starting in bursa beneath tendo Achillis.
	20.	Synovitis of knee-joint.
	21.	Early caries of lumbar vertebræ.
	8.	Malignant parotid tumour. Removal of growth.
	—.	Multiple pyæmic abscesses. ? Glanders.
	15.	Small hard lump in iliac fossa, right. ? Enlarged gland along corner of iliac vessels. ? Appendicitis.

CASE UNDER MR. SYMONDS.

MARTHA	14.	Appendicitis, recurrent. Removal of appendix.

CASE UNDER MR. DUNN.

MARTHA	12.	Spasmodic torticollis.

CASES UNDER MR. LUCAS.

LYDIA.

15. R. P., æt. 3½. Admitted June 21st with the following history. Four days ago he was kicked on the shin, and afterwards was noticed to limp. Two days later he could not put his foot to the ground, and the next day the leg was noticed to be swollen and somewhat reddened.

On admission.—Patient was decidedly ill; temperature 103; pulse 140, feeble. There was a tense swelling of the right leg, extending from the knee nearly down to the ankle. It was red and hot, and deep fluctuation can be obtained. There was also greatly impaired movement in the knee-joint, an attempt at movement causing great pain. The left ring-finger is swollen, red and tense. An anæsthetic was given at once and an incision about five inches long made along the inner border of the tibia. The superficial tissues and muscles were infiltrated and unhealthy looking. The periosteum was ragged and separated at the upper and lower ends of the wound, and bathed in foul pus. A needle was put into the knee-joint, but no pus was found. The wound was packed with iodoform gauze.

22nd. Child still very ill, rather cyanosed. Râles audible all over both chests. Temperature ranges high, 105 at 6 p.m.

23rd. Temperature rose at 6 a.m. to 106. Child died at 10 a.m.

Autopsy.—The pericardium was covered with recent lymph, and contained some sero-pus. Several abscesses were present in the heart muscles. There were patches of broncho-pneumonia present in both lungs, the patches in some places breaking down to form abscesses. There were also numerous minute abscesses in the kidneys.

CHARITY.

22. J. T., æt. 3¾. Admitted June 26th for abscess of right arm. A week before admission, patient fell on to his arm. Next day it was very tender and painful, later it became swollen and red, and the swelling gradually extended down to his hand.

On admission.—The child looked very ill; pulse, rapid and feeble. The right arm was markedly swollen and red, the superficial veins being distended. There was œdema of the whole arm, forearm and hand. Temperature, 98·2. Well-marked pericardial rub was heard.

An anæsthetic was given, and an incision was made on the outer side of the arm; the whole of the periosteum was found to be separated from the humerus by a collection of thick reddish yellow pus. The incision was enlarged so that it extended nearly the whole length of the bone. The shoulder and elbow joints were unaffected. The wound was packed with iodoform gauze, and hot boracic fomentations applied every hour. At 12 p.m. the same night no pericardial rub could be heard; the cardiac dulness extended up to the second space, and no apex beat could be made out.

27th.—Child slightly better, but the cardiac dulness now extends up to the second rib; temperature 99·8.

28th.—Patient does not seem so well; pulse feeble and rapid, 160; temperature 97·4. A few râles audible at the left base. The child died on the 29th at 4 a.m.

Autopsy.—The whole of the periosteum was found to be separated from the right humerus, and the upper epiphysis became detached in removing the humerus. The medulla was injected, and contained a small breaking down patch at about the centre of the bone; other bones and joints unaffected. The pericardium was distended with six and a half ounces of sero-pus, and both surfaces of the membrane were covered with a thick layer of lymph. Several small abscesses were present in the left ventricle. There were a few patches of broncho-pneumonia in the lungs. One or two abscesses found in the kidneys; other organs healthy.

A noteworthy feature about the case was the fact that the temperature was only on one occasion above 100, and then it was 100·6, in spite of the condition of general pyæmia.

Case under Mr. Golding-Bird.

Martha.

Cot B. A.D., æt. 18 months. Was admitted under Dr. Hale White, for bronchitis following measles, on June 4th. This partially cleared up, but on June 22nd, the child was noticed to have limited movement in the right hip, together with a large fluctuating swelling in Scarpa's triangle. Temperature ranged between 100 and 102. She was then transferred to the surgical wards, under Mr. Golding-Bird. On examination under chloroform, distinct grating was made out in the hip-joint. An incision about three inches long was made over the great trochanter and the hip-joint opened. A large quantity of pus escaped, and the head of the femur was found to be loose and was removed. The acetabulum was felt to be rough and denuded of cartilage in its upper and outer part. A large pocket was found extending back beneath the gluteal muscles. The wounds were well irrigated and a drainage tube inserted. The legs were slung up vertically, the sound leg acting as a splint.

July 3rd. Patient doing well; wounds mostly healed.

5th. A small abscess formed on left upper eyelid.

7th. Abscess on eyelid broken and healing up under hot boracic.

10th. Two or three swollen red prominences noted over ilium at back, and a small abscess in left thigh was opened.

11th. Patient not so well. Pulse small and thready. Some purulent pus was discharged from wound: inflamed areas on back increasing.

12th. Pulse still very rapid and bad; temperature 100. Less discharge from wound.

15th. Condition improved.

Case under Mr. Dunn.

Samaritan.

9. H. N., æt. 15. Admitted June 27th for inflamed left elbow and right leg. On June 21st, patient knocked his leg against an iron railing. Two days later it became painful and began to swell. He gave up work and rested, but had great pain, and shortly afterwards the left elbow became painful, red and swollen.

On admission.—The right leg from knee to ankle was swollen, tense and brawny, and covered with a red blush. The left elbow was swollen, red and very painful. The boy was markedly ill. A pericardial rub was present and was best audible in inspiration.

An anæsthetic was given, and an incision about six inches long was made on the inner side of the right tibia down to the bone. The periosteum was found to be separated from the tibia, throughout its whole length, by a quantity of foul pus. The left elbow-joint was opened, and about ʒss of pus let out.

28th. Patient seems a little better. Temperature at 6 a.m., 104. Pericardial rub no longer heard, but there is a slight pleuritic rub.

29th. Slight collections of pus, which had formed at upper part of left ulna, and upper end of right tibia, were evacuated. Temperature 103.

July 2nd. There is a tender red swelling over right sterno-clavicular joint. Temperature not so high. Wounds more healthy looking.

4th. Sterno-clavicular swelling has nearly disappeared. Patient much better.

6th. Mr. Dunn opened two abcesses last night—one over upper end of left ulna, the other on outer side of tibial wound; the latter was opened from behind, and a drainage tube was left in. Patient has bad diarrhœa. Temperature 102, pulse 100, respiration 32.

7th. Patient much better. Temperature 98·6, pulse 88, respiration 32. No diarrhœa.

10th. Patient complained of pain in left ankle; there was some discharge from right ear, which was syringed out three times.

12th. Patient improving; discharge from ear ceased; drainage tube removed from leg. Patient sleeps well, and has good appetite.

15th. There has been more discharge from ear.

17th. Patient continues to make improvement. Temperature, on the whole, moderate.

Vacant Appointment.

Applications are invited for the post of Anæsthetist in the Dental School, and should be addressed to the Treasurer, Counting House, Guy's Hospital, S.E., not later than Saturday, August 4th, 1894. Particulars of the duties of the post may be learnt upon enquiry of the Dean.

Passim.

OUR congratulations are due to the cricket eleven, who, after an excellent season's work, have won us the Challenge Cup for the fifth year in succession. Since the institution of the competition Guy's have won the Cup altogether ten out of thirteen times, an achievement of which we may be assuredly proud. At the United Hospitals Sports, a full account of which appears under "Sport," Guy's experienced very hard luck in failing to retain the Shield. We feel the result would have been different had Bell been quite fit. Every praise is due to him, however, for the plucky manner in which he performed even when suffering under the severe disadvantage of an injured foot. This contest is, we believe, the first in which only two hospitals made anything like a show—a fact much to be deplored; save for a second place obtained by St. Mary's in the mile, Guy's and St. Bartholomew's carried all before them.

THROUGH pressure on our space we are reluctantly compelled to leave over, until next issue, several interesting contributions and cases, including an account of the Guy's Rifle Association doings. St. Thomas's again won the Cup, Guy's taking but a poor position in the United Hospitals Competition.

WE publish in another column a contribution from Mr. Tubby, which will be found most interesting reading. Mr. Tubby, who, in conjunction with Drs. Taylor and Savage, is a member of the Alpine Club, makes the suggestion of forming an Alpine Party from Guy's, which in these days of party travelling, might with advantage be carried out at Guy's. All Guyites will regret that Mr. Tubby's term of active work at Guy's expires shortly. He is one of many who have had a brilliant career at their old School. In 1884 he was awarded the prize for the best essay read before the Physical Society, on "The Diagnosis and Treatment of the Hip Disease," he obtained Honours at the Intermediate M.B. London, in Anatomy and Materia Medica, in 1885, and two years later passed the examination for the final F.R.C.S., England, and final M.B., London, at which examination he took the Gold Medal in Medicine, with Honours in Forensic Medicine; at the examination for the final B.S., he also obtained the Gold Medal in Surgery. The following year he had the rare distinction of carrying out the duties of House Surgeon and House Physician; and in 1890 he obtained the degree of M.S. He has contributed several valuable papers to the Guy's Hospital Reports, and was one of the Committee of the GUY'S HOSPITAL GAZETTE, when the present series was started.

WE have received further correspondence in connection with the College letters. The grievance is one which, in the experience of everyone, is so apparent, that we hope it will receive the close attention of the proper authorities.

Pass List.

University of Cambridge, June, 1894.

SECOND EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

PART II.

Carter, A. B. Jephcott, C.

Second Conjoint Examination, July, 1894.

(UNDER OLD REGULATIONS.)

ANATOMY AND PHYSIOLOGY.

Adams, A. R. Lee, F. W.
Carter, A. H. Mottram, G. N.
Fulton, H. Nicholson, C. R.
Hitchins, F. C. Pomeroy, E. H.
Todd, D. B.

ANATOMY ONLY.

Higgins, P. C. Peile, H. D.
Ponsonby, J.

PHYSIOLOGY ONLY.

Clowes, E. F. Rowland, R. S.
Francis, C. J. Smith, D. L.
Vick, T. J.

(UNDER REGULATIONS DATED JANUARY 1ST, 1892.)

ANATOMY AND PHYSIOLOGY.

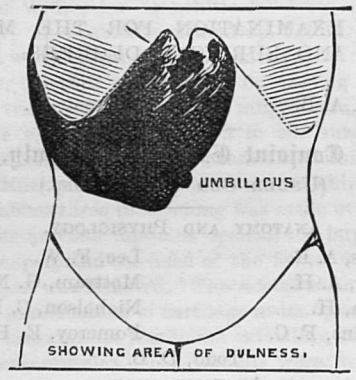
Bernard-Onraët, H. Hull, A. J.
Dixon, J. Kinsey-Morgan, A.
Evans, Edward Marsh, H. R.
Falwasser, A. T. Moore, P. W.
Fuller, W. A. Mossop, C. H.
Gough, B. B. Regnart, H. C.
Harvey, W. J. S. Simson, H.

Notes from the Tropics.

WE have pleasure in inserting the following interesting notes from Mr. F. A. Robinson, who is a medical missionary in Central Africa :—

Some cases of interest having come under my care, I thought it worth while to send a short summary to show my colleagues that even in these outlandish places cases worthy of record occur.

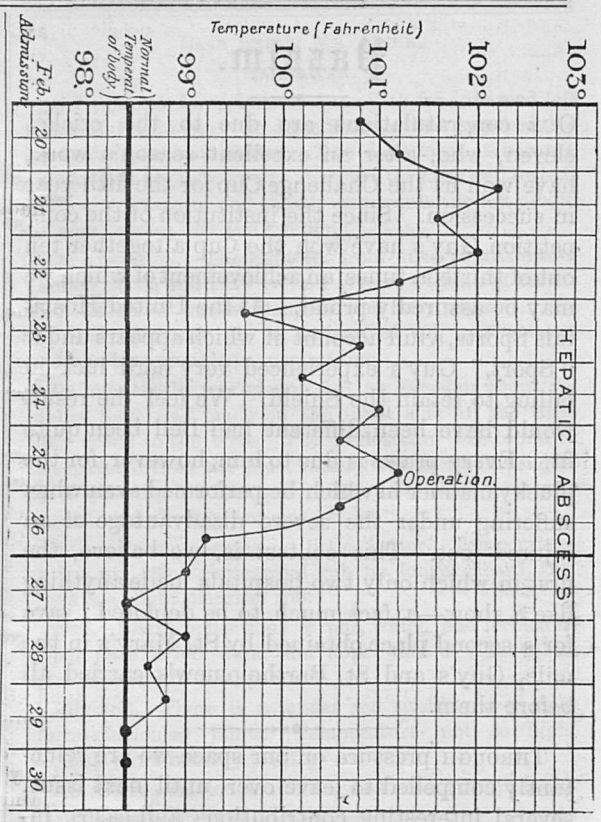
CASE I.—Native Christian woman, æt. 34. No previous illness remembered. Came complaining of pain in right side in December, 1893. Had her under treatment for three weeks. Liver slightly enlarged, and painful on firm pressure. Slightly jaundiced. After three weeks' rest and treatment with quinine and ipecac., felt better and returned home. I was away for three weeks, and on return found her again worse, complaining of constant pain in hepatic region. I had her taken up to station, and on examination found the liver enlarged, extending below umbilicus. Edge smooth. No inequalities to be felt, save below umbilicus, where there was roundish nodule. The liver was painful and tender, and patient describes pain as that of an abscess. There was slight bulging of ribs by swelling. The



diagnosis of hepatic abscess was made, and on February 26th $CHCl_3$ was given, an incision was made over the most prominent part of the swelling, three inches external to umbilicus. The liver was found to be adherent to abdominal wall. It was incised to depth of half-an-inch, when a large thick-walled abscess sac was exposed. This being opened, two pints of pus were evacuated. Characters of pus were sweetish sickly odour, of a yellow colour. Microscopical; no hooklets found.

Drainage-tubes were inserted and antiseptic dressing applied. A fortnight after operation patient could walk about, and two weeks later was discharged. The wounds have healed completely.

No cause could be assigned for abscess. The following is the temperature chart of case.



CASE OF MASTOID DISEASE, WITH THROMBOSIS OF LATERAL SINUS.

CASE II.—Patient æt. 20. Three years ago had discharge from both ears. Came to me a month ago complaining of pain and discharge from ears. Thick offensive discharge from left ear, and slight from right. Perforation of left drum. Patient progressed satisfactorily, ears being syringed out with warm boracic and zinc lotion three times a day, till Monday, March 19th, 1894, when I was suddenly called to him. I found him in great agony, complaining of sharp pain in left side (axillary region). He described it as "shooting down his neck, and cutting into his side." Temperature 102. His pain was relieved by very firm pressure. On auscultation a few râles could be heard, but no pleuritic rub. He began to expectorate foul sputum. No hæmoptysis. That night he had a rigor. *Tuesday* 20th had intense pain in right side, of a similar character, relieved by pressure, and again had a rigor. Pain had gone from left side.

Wednesday morning.—Pain, but not so intense, in region of spleen. No pain in either lungs. Temperature 101·4. He seemed worse, so decided to operate. No pain on pressure or percussion over mastoid process.

Patient was given $CHCl_3$, and usual T shaped incision made. Periosteum very adherent. With aid of Lane's rectangular gouge mastoid cells were examined and found to be necrosed. The lateral sinus was exposed,

and, being of a yellow colour, I put a needle in and found it thrombosed. The internal jugular vein was then ligatured. The sinus opened and clot removed. The antrum was opened. The tympanum cleared and quill tube inserted for drainage. The wounds were sewn up and patient put to bed. The operation lasted four and a half hours, which was due chiefly to the lack of skilled help, as two out of three of my assistants had not been at an operation before. The operation was followed by a cessation of all symptoms, save that the sputum was offensive for a few days.

By some unfortunate accident, a week after the operation, the wound in neck became septic and cellulitis set up, but by constant application of hot carbolic compresses this has been got under, and the patient is on a fair way to recovery. The interest of this case, besides the fact of its being, as far as I know, the first treated in Central Africa, lies in the sudden onset of lung symptoms, probably due to some emboli causing slight infarctions in lung and spleen. I do not remember having seen any similar symptoms noted in published cases, at least in the early stages of the disease.

Likoma, April, 1894.

The Biennial Dinner.

THE Biennial Dinner was attended by some two hundred and thirty Guyites and their guests, on Wednesday, July 4th. On the right of the Chairman were the Treasurer, S. Hoare, Esq., M.P., Dr. Wilks, Mr. Howse, Dr. Pavy, Mr. Lucas, Drs. Holman, Galabin, Stevenson, Brett, and the Chaplain; to the left were Sir Cameron Gull, Mr. Bryant, Drs. Pye-Smith, Fotherby, Braxton Hicks, Messrs. Durham, Galton, Golding-Bird, and Drs. Owen Lankester, Goodhart, and Parry-Jones. There were also present, Drs. Hale White, Shaw, Newton Pitt, Perry, Horrocks, Starling, Campbell, Bryant, G. B. Smith, J. Fawcett, C. H. Ogle, W. A. Phillips, F. E. Burton Brown, C. T. Brookhouse, J. K. Will, J. W. Pare, C. Gross, R. Eager, D. W. Samways, J. G. Ferrier, W. J. Tyson, J. C. Uhthoff, E. C. Beale, F. P. Weaver, J. Tanner, A. E. Price, W. H. Lamb, W. C. James, A. M. Daldy, F. Wyatt Smith, A. P. Price, G. Carpenter, C. W. Chapman, W. R. Dakin, R. W. Brogden, D. W. C. Hood, J. W. Smith, R. M. H. Randell, S. W. Owen, R. T. Carter, F. R. Bishopp, W. F. Clarke, H. W. Drew, F. Shirley Murphy, F. C. Turner, F. H. Berry, E. Penny, W. Cock, F. W. Cock, A. C. Roberts, M. Carnelly; Messrs. Jacobson, Symonds (Hon. Sec.), Lane, Dunn, Higgens, Brailey, Targett, Tubby, Groves, Reinold, W. L. Purves, Tom Bird, F. N. Pedley, G. Rowell, H. Stoner, Jabez Thomas, F. Durham, J. E. B. Burroughs, A. Gillingham, R. Barlow, John Davies, H. M. Brownfield, H. L. Evans, E. Davies, H. A. Davies, W. T. F. Davies, R. W. Rouw, F. K. Holman, J. Walter Scott, R. Hilder, J. Milward, J. H. Ewart, P. Minns, F. Vicars, J. E. Coulson, A. L. Allworth, A. H. Dodd, A. Parkin, R. J. Freeland, J. Dutton, G. H. Graham, E. E. B. Landon, W. Jackson Lang, E. Younger, H. O. F. Butcher, A. E. Pillin, G. Eastes, G. Mickley, M. F. Hopson, O. Richards, W. R. Wood, S. Keele, S. C. B. Shadwell, J. H. Gibson, R. R. W. Oram, L. E. W. Stephens, E. C. Roberts, E. R. Ray, H. Lyne, P. Warner, C. Knox Shaw, R. Wornum, G. Porter Wornum, F. G. Harvey, Arthur Bull, G. Loly, Holland Wright, W. E. Brett, F. W. Humphreys, W. F. Cleveland, S. H. Armitage, J. H. Walters, J. W. Penfold, W. Spong, H. B. Bolus, H. V. Hickman, E. P. Mowrilyan, R.N., F. E. Cave, F. R. Humphreys, J. C. Bates, E. J. D. Mitchell, E. J. E. Hamilton, J. H. Hooker, J. Hayes, W. P. Reynolds, J. B. Howell, E. C. Greenwood, W. H. Dodd, J. W. Cruickshank, M. M. Hailey, P. N. Randall, R.N., R. Stow Armstrong, B. Scott, R Bredin, C. A. G. Barrow, H. I. Berry, R. Elphinstone, I. A. J. Howell, J. E. Fletcher, F. Beard, H. E. Counsell, E. Du Buisson, H. R. Ker, Surgeon-Colonel Hall, Surgeon-Major Ince, Surgeon-Captain Childe, Surgeon-Captain Spong, Surgeon-Captain Salvage, and Surgeon-Colonel Barrow. Amongst the visitors also were Drs. W. Wilson, J. Loame, Percy Smith, Danford Thomas, W. G. Bott, J. N. Maclean, and Messrs. W. S. Thomson, A. G. Fawsett, G. S. Brookhouse, W. E. Rigden, T. M. Nicholson, H. F. Greig, F. Constant, F. Morton, A. E. Bridger, A. G. Witherby, Berkely Bennett, J. Chalmers Hunt, Bradshaw, W. Rawes, Percy de Bathe, George Tite, F. G. Harvey, C. W. Coe, J. E. Fletcher, W. J. Johnson, H. C. Sharp, W. Poole, J. A. Howard, A. J. Sharp, F. Meadows Turner, F. G. Hopkins, H. J. Spon, J. B. Berry, W. A Slater, J. F. Still, G. Lawrence, A. Channing Pearce, J. B. Leathes, Bowen Jones, R. Koettlitz, Halse Francis, C. J. Routh, Matcham, and C. Otway.

We went to the Biennial with the fullest intention of conscientiously reporting the varied eloquence which the occasion always calls forth. A glance at the list of speakers made it certain that a high standard would be reached, and this expectation was undoubtedly justified. The reporter alone was found wanting. After-dinner speaking is a high art, but after-dinner reporting is a more difficult one—at least, for the amateur. When the sonorous voice of the toast master warned us that the time for action had arrived, that tender variety of a subtle thing—the conscience editorial—was asleep. Alert when we sat down, its voice was now no longer heard. It seemed such a simple thing to ask the speakers afterwards for notes of their speeches. But as these, in the sequel, turned out to be, for the most part, non-existent, the many happy ideas and well-turned phrases which delighted all who were present will be found in the memories of these alone. Happily the remarks of the Chairman have been preserved in full. In proposing the first toast, "The Queen and Royal Family,"

Mr. DAVIES-COLLEY said: Gentlemen, the first toast which, as your chairman, I have the honour to submit to you is the health of our Queen and every member of the Royal Family. When we remember the convulsions which have shaken nearly every great country during the last half century, we ought to be very grateful to

our Queen, to whose goodness and sagacity we owe so much of the stability and prosperity which this country has enjoyed. We trust that she may long be spared to reign over us, and to give to the world a bright example of queenly dignity and every womanly virtue. It is also a great satisfaction to us to know that those who will have to succeed her—let us hope many years hence—are continually showing, by their activity in every good work, that they inherit many of the good qualities which have made the name of our Queen so illustrious. Gentlemen, I ask you all to drink to the long life and happiness of our Queen, the Prince and Princess of Wales, and all the Royal Family, not forgetting the Duke and Duchess of York, and the little prince whose birth has just been hailed with so much joy throughout the Empire.

The mention of the fortunate infant, with Mr. Colley's loyal sentiments generally, awoke much enthusiasm.

Next the CHAIRMAN gave "The Army, Navy, and Reserve Forces." He said: Gentlemen, there is not much advantage in having a good Queen and Government, unless that Government has behind it a force which will maintain respect at home and abroad. We believe that we have such a guarantee in our Army, Navy, and Reserve Forces. It is true that our Army is a small one as compared with the mighty hosts of men of our continental neighbours; but in efficiency and in experience of every kind of warfare, I have no doubt that it is second to none. As for our Navy, we know that it has long been, and we trust that it will long continue, without a rival on the face of the globe. In the successful management of warfare, both by sea and land, it is essential that the greatest care should be taken of the health of our sailors and soldiers. Hence the Medical Department of our Army and Navy is of the utmost importance, and I am glad to find that of late years there has been a fuller appreciation of the debt which the country owes to the officers of this department. We, of Guy's, are especially interested in this Service, as we send to it many of our ablest students. One of these, not many years ago, obtained the Victoria Cross for the heroism with which, under a heavy fire, he devoted himself to the care of the wounded, and in all the wars which are continually being waged upon the fringe of our great empire, Guy's men will be found to the front winning distinction for themselves and their old School. Gentlemen, I give to you the toast of the Army, the Navy, and the third line of our defence, the Reserve Force, coupling with the toast the name of one who has done good service in Egypt and many other parts of the empire, my old friend, Surgeon Lieutenant-Colonel Frank Barrow.

Surgeon-Colonel BARROW responded: He said that he had had the pleasure of being associated with several other Guy's men in the Service, and could speak for their high qualities. The Army Medical Service was now on a satisfactory basis, and they enjoyed the due recognition of their proper rank; but they were not quite fully satisfied. Their friends in the Navy seemed quite happy, and he was told they desired no change. He would not say that for his own branch. They desired to be constituted as a duly recognised Army Corps. Such a step was desirable from every point of view, and though there was at present much opposition, it was bound to come in the future. For the Reserve he was unable to speak, but he had no doubt of its efficiency—(there were here loud calls for a distinguished member of the Volunteer Service; but not wishing to favour an "unauthorised programme," the gentleman referred to remained seated).

"Prosperity to Guy's" was then announced, and

Mr. HOWSE rose with obvious pleasure to handle so agreeable a theme. He thought his was not quite the toast of the evening, that came next; but his duty dealt with what was almost the same thing, for the prosperity of the Hospital and that of the Medical School were inseparably bound together. Mr. Howse then went on to review the many evidences of the present efficiency of the Hospital. Guy's had plenty of muscle, bone and brains, all that was necessary was the due supply of a nutrient fluid. What they wanted to ensure continued prosperity was plenty of those yellow round bodies which are the blood corpuscles of hospitals and kindred institutions; he hoped the gentleman who was to reply to this toast would come to receive on behalf of Guy's, a greatly increased quantity of these golden corpuscles.

The Treasurer, Mr. LUSHINGTON, responded. He was always anxious to gather in for the Hospital as many as possible of the corpuscles mentioned by Mr. Howse, and in addressing so large a number of Guy's men as he saw before him, he felt no little hope that they would be able by their influence to direct a stream of these in the right direction. The Treasurer proceeded to congratulate the Staff on the work it was doing. There was one thing he hoped though, and that was this, that when the members went on to the consulting list they would not all write books. He had just received Dr. Pavy's new book, and though he knew it was a *magnum opus*, it was a difficult matter for him to tackle it. He had been accustomed to look upon sugar as deleterious, and had avoided it, but he seemed to gather that our views on these points were to undergo some change, and that sugar was not worse than other things. Now he had up till now refused countless glasses of sweet champagne; if it was going to be shown that such denial was unnecessary, he regretted to think he was now not likely to have the opportunity of making up for lost time!

The CHAIRMAN now proposed "Prosperity to the Medical and Surgical School," and said: Gentlemen, I have now to propose a toast which is of the greatest interest to all those present, the prosperity of the Medical School of Guy's Hospital. I suppose that since the foundation of our School there has never been a period of greater activity and more rapid development than the last ten years. Under the careful guidance of our Treasurer, and aided by the indefatigable energy of our Deans—Dr. Taylor, Dr. Perry and Dr. Shaw—the most strenuous efforts have been made to improve our School

and to satisfy the ever-increasing requirements of modern science. The result of these efforts has been, as you all know, not only to make our School larger than it has ever been before, but to place it for the first time for many years at the head of all the great Medical Schools of London. Gentlemen, this is a proud position, but it is also one which it is difficult to maintain. We must all use our energies if we would keep up the glorious reputation, and carry on the work which has been left to us by such men as Bright, and Addison, and Gull, by Astley Cooper and John Hilton, to say nothing of the great names of those who have more recently left us. There is much still to be done. Already we are discussing great projects. Like the rich man of old, but unfortunately without his wealth, we are talking of pulling down our barns and building greater ones, as we trust that before many years are past we may find means to erect such a school building as shall be worthy to stand by the side of the great Hospital with which it is connected. Gentlemen, there are many reasons why we should drink the toast. It is to schools like Guy's, to the work which is being done there by the students, whether they be pupils or teachers, that the country is indebted for most of the recent progress of Medical Science. Our great School is also the manufactory in which the raw material of the medical student is continually being worked up into the finished product of the qualified practitioner, and we send this product far and wide, to carry healing, and the light of science, to every quarter of the globe. But further, when I add to this, that Guy's is our own beloved Alma Mater, that it is associated in our memories with one of the happiest periods of our lives, with many a valued friendship, with the names of revered tutors who have passed away, with the fierce struggle of many an intellectual and athletic contest, with long years of patient and not unsuccessful toil, I feel sure that you will drink with enthusiasm to the success of the dear old School. Further, I will not associate this toast with the name of any individual. I prefer to consider that you are all alike interested in the success of our School, and I therefore ask you all to respond by your acclamation to the toast of the Prosperity of the Medical School of Guy's Hospital. The toast was received with immense enthusiasm.

"The Consulting Staff" was then proposed in a most humorous speech by Mr. CLEMENT LUCAS. He first dealt with his own recent severe illness, and spoke of the losses it had occasioned him. In the first place he told how one of his neighbours had shot all his pheasants, because he (Mr. Lucas) "was sure to die, and wouldn't want them down below." Then there was a certain young lady who, when the speaker was laid aside, went and got engaged, explaining that she couldn't wait till Mr. Lucas was "Senior Physician" ("she must have been thinking of Dr. Pye-Smith," was here suggested). Then, after referring to the chairman's prosperous farm, which abutted on his own "barren acres," and when the hedges were all in efficient splints and the fields treated with the best of "dressings," he dexterously turned the current of his remarks (which till now had been apparently somewhat wide of the mark) to the merits of the consultants, and paid them a handsome eulogium, which was very heartily applauded. At this point we were tempted into the neighbourhood of the end table, where sat the more junior portion of the diners. This region was anything but quiet, and we did not properly hear the replies of the Consultants; but to judge from the demeanour of others, what they had to say was much appreciated.

Dr. WILKS spoke first, and then Mr. BRYANT. Afterwards, in response to a most urgent call, Dr. PAVY rose, and he was followed by Dr. BRAXTON HICKS. Mr. Lucas had alluded to Dr. Wilks as one who "ought to be President of the College of Physicians, only having missed the position by a minute majority of votes," and had reminded us of Mr. Bryant's distinguished position, so that, altogether, with Dr. Pavy's epoch-making book before us, by the time Dr. Braxton Hicks' well-known voice had ceased there was a general glow of pride in the presence of our Consultants.

In a charming little speech, Dr. PYE-SMITH now proposed the "Givers of Prizes."

SIR CAMERON GULL in replying, made a graceful allusion to his great indebtedness, through his father, to Guy's Hospital. To found a Scholarship was no great thing. The labour involved in medical research was, on the other hand, a thing for which all the world had reason to be grateful; one felt on such safe ground in founding any prize for the encouragement of Science, and especially of Medical Science. In the domain of Theology or Law for instance, the matter might be different. Research in the former might lead to nothing but a new heresy, and he did not know that there was much promise in the latter, but in Science, one could scarcely do wrong. He thanked the community of Guy's for their invitation to that dinner, and for the kind way in which they had received his name.

Mr. SAMUEL HOARE, M.P., then replied to the toast, and finally Mr. DURHAM. The latter rose amid great enthusiasm and applause. He was exceedingly glad, he said, to hear that the little prize he had been able to establish had done good work on the lines intended. It was founded because he thought that in these days of section cutting, and other things, the art of careful dissection was becoming too much neglected. One of the previous speakers (Mr. Hoare) had hoped that he (Mr. Durham) would tell them something about his old coachman! Well, he was glad to say his old servant was hale and hearty; he was also apparently prosperous, for a longer time than usual had elapsed since he had called for his customary dole! Mr. Durham then went on to speak of his past connection with Guy's, and of his regret at giving up work there.

Mr. GOLDING-BIRD then proposed "The Past and Present Students of Guy's." His speech was good hearing, both for past and present, each of whom had very nice things said of them. Speaking of the present

conditions of life at Guy's, he remarked that some had complained to him of the disappearance of "the rooms." It was not true; the rooms still existed. The better part of their privileges was still enjoyed, and under improved conditions. The old Bohemianism might have partly disappeared, but what had gone was not to be regretted. He alluded to the new class of Guy's men, the Dental Students, and felt sure that the Hospital was going to be proud of them.

Mr. E. H. GALTON, always an acceptable after-dinner speaker, replied for the old Students, and Messrs. A. J. SHARP and W. J. JOHNSON for the new.

Dr. GOODHART gave "the Chairman." After referring to the absence of Dr. Taylor, and its most regrettable cause (the recent death of his father), Dr. Goodhart paid a deep tribute to the genius of Mr. Davies-Colley, and his remarks were enthusiastically applauded.

The CHAIRMAN, having replied, he then proposed the health of Mr. Symonds, the Secretary of this year's festival.

Mr. SYMONDS, in replying, gave some interesting statistics, and read some letters of regret from absentees.

During the evening Mr. J. E. Coulson sang in his well-known pleasing manner a much appreciated solo; while an excellent programme of music was performed by the Bijou orchestra.

A Mountain Holiday.

To him who, like Dr. Johnson, when Boswell had succeeded in lugging him into the wilds of the Highlands, thinks with fond regret of the ideal prospect of Charing Cross, or the shady side of Fleet Street, and is convinced that he is rather a fool for suffering himself to be dragged into the regions of bog and heather, the following short remarks on an Alpine holiday will not appeal. He will feel, like Dr. Johnson, that "it is easy to sit at home and conceive rocks, heaths and waterfalls, and that these journeys are useless labours, which neither impregnate the imagination, nor inform the understanding." But to him, who feels that for eleven months in the year "we all read the same newspapers, talk the same things, are bound by the same laws of propriety, and are submitting to uniform imposition of dull respectability," as if we were under the orders of a Prussian drill sergeant, there are places of refuge in the Alps where he can cast away the black coat and hat, and escape from himself and from his neighbours, breathe air that has not passed through a million pairs of lungs, revivify his moral nature by contact with grand and noble scenery, and brace his muscles by continual exercise which has just that spice of adventure in it to render it all the more pleasant.

To such an one as the latter, I would say let him get at once, a copy of Mr. Dent's book on mountaineering, in the Badminton Library Series, and read it with due diligence. Therein he will discover that skilful mountaineering is a true science, that nearly all difficulties can be avoided with prudence and foresight, and that dangers which cannot be avoided are bad weather and falling stones. That the so-called Alpine accidents so frequently gloated over by the daily press are not Alpine in the true sense at all, but are due to simple matters, such as walking carelessly on waterworn rocks with hob-nail boots, or taking a stroll on Sunday afternoon up steep and slippery grass slopes, in thin shoes, intent on catching butterflies it may be. Too often danger is courted by distinct wilfulness and disobedience to the guide's instructions. Some perverse travellers scorn the rope until they learn that it gives them a sense of moral security and often prevents them endangering their own safety, or what is worse, the safety of the whole party. Men get careless and too confident; this does not matter or the other does not matter. Everything matters; precaution should not only be ample, but excessive. The prudent climber will not go where avalanches are in the habit of falling after fresh snow, or wander about under an over hanging glacier in the heat of a summer afternoon. With these cautions in his mind, let him seek one or perhaps two trusty friends, and *friends* they must be, as many a so-called friendship wears very threadbare after a month's roughing it. Having packed up a small bag containing a complete change of clothes, a stout broad-soled pair of lace boots, the soles of which will stand nails being driven into them for half-an-inch without coming through, and particularly roomy in the toes; several pairs of socks or stockings, a pair of slippers, some simple ointment, such as lanoline, the usual toilet necessaries, and a sweater, which is often valuable, especially in the early morning; he should then take a second-class return ticket, say to Lausanne, the cost of which is under one hundred shillings, and start out for his expedition, other necessaries being obtained on the spot.

On coming out fresh from town no big thing should be tried; it is most advisable to take training walks around a good centre, many of which are easily accessible from the Rhone Valley Railway at the further cost of a few shillings in addition to the fare to Lausanne. The question of further expense must necessarily arise. If our friend is of a sybaritish nature he will naturally seek some place, such as Zermatt, where huge caravanserais abound, live in the lap of luxury, and double his necessary expenses, he will, perhaps, in a few days, be found talking big about the peaks around, and retailing his second-hand knowledge to the new comers who gaze at him with undisguised admiration. It may be that he will be seen strolling through the fields with a brand-new ice-axe bought at the village shop; but such as these are not to be taken seriously. It may at once be said that there are sufficiently comfortable hotels to be found at less-known places, such as Zinal, Arolla, Saas-Grund, Berisal, Binn, and the Tosa Falls, where the cost of living *en pension* does not exceed six to eight francs a day. As to guides, at first they will not be needed for mere rambles; but if any snow or glacier work is attempted they are absolutely necessary. They may be taken at a fixed tariff for an individual peak or

pass, or their service may be retained for a few days at a fixed price. First-class guides, 50 francs per peak, 25 francs a pass, and 10 francs for off-days and small expeditions. A good but little-known guide will offer himself at a much less rate, viz.: 30 francs per peak, 15 francs a pass, and seven francs for off-days; and even first-class guides may be obtained at this tariff in July and September, so that if three are in the party the cost of the guide being divided does not fall severely on each.

From one of the places above mentioned many expeditions to minor passes and peaks may be attempted, sufficient to occupy a fortnight or three weeks. Advice as to their duration, and any difficulties that may be encountered, should always be sought from more experienced travellers before starting. It would, perhaps, be unfair not to mention that the mountaineer must be an early riser; for expeditions, especially those across snow, it will be necessary to start at 2 a.m., or thereabouts—too often it is thereabouts—a quarter of an hour late in starting, be it remembered, often means an hour's longer work in the day when the snow is soft, which proves that unpunctuality is the thief of time. The yawning discomfort of a cold and early start is more than compensated by the glories of a sunrise such as may only be seen in the Alps. By starting early one gets to one's destination, or down from one's peak early in the afternoon, in time for a bathe and change before dinner; after dinner, under the soothing influence of a pipe, there steals over one that excessive sense of virtue which arises invariably after early rising, a good day's work well done, and some difficulties met and overcome, together with a sense of *bien être* which follows a good dinner and accompanies a perfect digestion.

A word or two about that all-important point—the weather. July and September are generally better than August; there is less rain and less chance of mists obscuring the views. To such as really love the mountains for their own sake, for the health and happiness they bring, I would say, by all means try them, but let not climbing be undertaken merely for the sake of gymnastic exercises or a spirit of record-breaking, although it is well known that our countrymen naturally do the shortest times. There are some people whose only recollections of a peak or pass consists in the knowledge that they did it in so many hours and so many minutes. To them a peak is only a thing to be scaled at all costs and at all hazards. I can only express the hope that the Guy's Hospital Clubs' Union will include, among its many advantages, holiday programmes which will embrace in the future expeditions such as I have mentioned, and that there may develope at Guy's, men who having done their preliminary work in the Alps, will be fitted to share in explorations further afield. I believe there are some amongst us who, in other years, would gladly place at the disposal of future climbers whatever knowledge and experience they may possess, and might be induced to take out small parties from time to time.

A. H. TUBBY.

Sport.

Cricket.

GUY'S v. ST. THOMAS'S.

FINAL CUP TIE.

THIS match was played on the ground of the Honor Oak Cricket Club, on Monday and Tuesday, 9th and 10th July. Thomas's were reported to be strong in batting, but weak in bowling; the latter they certainly were, but their batting never looked very dangerous in this match, and—thanks mainly to the fine all round cricket shown by Joyce—we won the Cup for the fifth year in succession, by ten wickets.

Francis won the toss, and decided to go in. The wicket was soft, but not difficult, and Trouncer and Perks went in first. The former was caught at point off the first ball bowled, and Hancock followed; but the game was very soon stopped by a perfect deluge of rain, which so swamped the ground that play was out of the question for nearly an hour. On resuming, Hancock and Perks took the score to 30, when the latter was caught at mid-on from a very weak stroke. Hancock did not stay much longer, being caught at long-on with one run added—three for 31. Shorland did very little, but Francis and Nicholls played carefully, and stayed together till lunch (?); they put on 34 for the fifth wicket—five for 71. Joyce came in, but after 32 more had been added, Francis was caught at short leg for a good 43. Joyce now began hitting freely, and though none of the others stayed long, except Pike, who played carefully for his 18, he just managed to reach his 100, amidst much applause, before the last wicket fell for the good total of 225.

Thomas's sent in Harding and Bingham, to face the bowling of Joyce and Shorland. The start was very disastrous, as the first three wickets fell for 10 runs, and there were four down for 27. Leechman and Ogilvie improved matters somewhat, the latter hitting freely, with considerable luck. The pair added 26 for the fifth wicket, when Leechman was finely caught at point. Yearsley never looked happy, and was caught at short slip without increasing the score. Maurice was caught at the wicket before he had scored, but no one appealed, so he hit two fours and two singles before he was bowled. Sedgwick played an excellent game, by far the best on the side, and his 46 included eight fours. The innings closed for 125, exactly 100 behind. Joyce took six wickets for 43 runs.

SECOND DAY.—Thomas's, of course, had to follow on, and began, as in the first innings, very badly. Rotherham again played well; Yearsley was vigorous, but very fluky, his runs being principally made by skiers over cover-point; eventually, he was very finely caught by Alexander at cover. Adair Thompson made some good strokes, and Sedgwick played sound cricket, as before, but the total only reached 115, leaving us 16 runs to get. These were obtained by Shorland and Hancock without loss.

Joyce bowled very well throughout, and in all secured ten wickets for 80 runs. Shorland took four for 27 in the second innings, but was rather expensive in the first. Our fielding was fairly good, but it has been much better; there were too many catches misjudged. Score:—

GUY'S.

1ST INNINGS.

A. Perks, c Ogilvie, b Sedgwick	13
C. A. Trouncer, c Leechman, b Yearsley	0
W. I. Hancock, c Bingham, b Sedgwick	17
C. J. Francis, c Rotherham, b Thompson	43
E. T. Shorland, b Yearsley	6
F. J. Nicholls, b Yearsley	19
J. H. Joyce, not out	100
R. B. Stamford, b Maurice	1
K. B. Alexander, lbw, b Thompson	3
N. H. Pike, c Ogilvie, b Elliott	18
P. C. Prince, c Elliott, b Yearsley	0
Extras	5
Total	225

2ND INNINGS.—W. I. Hancock, not out, 7; E. T. Shorland, not out, 10; Extras, 2; Total, 19.

ST. THOMAS'S.

	1ST INNINGS.		2ND INNINGS.
F. Harding, b Joyce	0	b Joyce	0
F. M. Bingham, b Shorland	1	c & b Shorland	1
A. Rotherham, b Joyce	13	b Joyce	18
F. C. Adair Thompson, c & b Joyce	6	c Nicholls, b Hancock	25
A. Leechman, c Nicholls, b Shorland	8	b Joyce	4
J. Ogilvie, c Joyce, b Hancock	24	c Stamford, b Joyce	8
J. H. Yearsley, c Nicholls, b Joyce	0	c Alexander, b Shorland	15
S. H. Maurice, c Francis b Hancock	10	not out	7
R. Sedgwick, b Joyce	46	b Shorland	14
C. F. Moggridge, b Joyce	6	c Perks, b Shorland	1
A. E. Elliott, not out	0	b Trouncer	14
Extras	11	Extras	8
Total	125	Total	115

GUY'S v. CRYSTAL PALACE.

Played at Honor Oak Park, and resulted in an easy victory for the Hospital team. W. I. Hancock played a fine innings of 59, not out. Score:—

CRYSTAL PALACE.

S. Colman, c Alexander, b Harris	2
E. G. Turner, c Fitz-Hugh, b Harris	29
F. Hill, c Hancock, b Harris	9
J. M. Gowerlock, c Wetherell, b Harris	12
J. N. Noakes, not out	31
H. Baker, b Hancock	1
W. F. Umney, c Fitz-Hugh, b Harris	0
C. Gardner, b Hancock	1
A. B. Ciprani, run out	1
H. R. Fadill, c and b Harris	5
W. Hay, b Nicholls	0
Bye	1
Total	92

GUY'S HOSPITAL.

C. J. Francis, b Noakes	16
W. I. Hancock, not out	59
F. J. Nicholls, b Gowerlock	26
Harris, c Gowerlock, b Umney	7
Extras	4
Total	112

A. E. Elliot, C. F. Moggridge, R. B. Stamford, K. B. Alexander, R. Fitz-Hugh, F. C. Wetherell, and E. D. Hancock did not bat.

United Hospitals Athletic Club's Sports.

THE twenty-eighth annual meeting of the United Hospitals Athletic Club was held on Saturday, at the L.A.C. Grounds, Stamford Bridge. The preliminary heats of several events were run off on Wednesday, leaving only the finals to be decided. Altogether there were twelve events, eleven of which counted in the competition for the Champion Shield, the bicycle race being omitted, while an open half-mile handicap fell through for lack of entries. It was fifteen minutes after the time fixed for the first race that a start was made, but by the time the end was reached the programme times were over an hour late. The jumps and weight took up a lot of time. Guy's won the championship in 1892 and 1893, securing it in the first-named year from St. Bartholomew's, who had had a run of seven wins. H. T. Bell started well for his club, but St. Bartholomew's then had a rare run, taking the half-mile, shot, hurdles, 220 yards, and high jump right off the reel. Cornish, in the sprint, beat Bell in decisive fashion, while Guy's champion also failed at the jump, Smith winning at 5 ft. 5½ in., and afterwards clearing another inch. Bell seemed altogether out of sorts, and it was a hard task for him to secure the long jump, a bruised heel affecting him not a little. The long distance races were both at the mercy of H. A. Munro. Despite having to make practically the whole of the running in the three miles, Munro improved upon his previous record time, 15 min. 17⅕ sec., by covering the distance in 15 min. 16 sec. Prior to this race Guy's had a chance of making the wins level by taking the quarter. Cornish, however, proved too good for last year's winner, both he and Mason finishing in front of Batchelor, on whom their hopes rested, and a hearty cheer announced the destination of the championship trophy. The company, which included a good proportion of ladies, was not a large one, still, those present certainly witnessed some interesting sport. A thunderstorm threatened towards the finish, but only a few drops of rain fell. The chief officials were—Judges: Messrs. A. F. Voelcker, M.D.; G. H. Turner, F.R.C.S.; and A. A. Bowley, F.R.C.S. Referee: Mr. S. K. Holman. Clerks of the course: Messrs. J. G. Turner, F.R.C.S., J. H. Bryant, M.D.; B. C. Green, P. Furnival, A. P. Square, and W. G. West. Timekeeper: Nat Perry. From the appended

details it will be seen St. Bartholomew's won the shield with six firsts and six seconds to Guy's five firsts and four seconds, St. Mary's securing the other second place. Details:—

100 YARDS CHALLENGE CUP (presented by St. Thomas's Hospital, 1882).—Holder, H. T. Bell, Guy's; time, 10⅗ sec. Record, B. B. Conolly, Guy's, 10⅕ sec., 1868. Heat 1: H. N. Collier, Guy's, 1; J. V. Worthington, London, 2. Time, 11¼ sec. Heat 2: C. V. Cornish, St. Bartholomew's, 1; H. T. Bell, Guy's, 2. Time, 11¼ sec. Heat 3: J. Johnston, St. Bartholomew's, w.o. Final Heat: H. T. Bell, Guy's (holder) 1; C. V. Cornish, St. Bartholomew's, 2; J. Johnston, St. Bartholomew's, 3. Also ran: H. N. Collier, Guy's, and J. V. Worthington, London. A capital race was won by two yards, rather more dividing the next two. Time, 10⅗ sec.

HALF-MILE CHALLENGE CUP (presented by J. G. Beaney, Esq., M.D., Guy's, 1879).—Holder, P. W James, St. Bartholomew's; time, 2 min. 2⅕ sec. Record, P. W. James, St. Bartholomew's, 2 min. 2 sec., 1893. A. Hay, St. Bartholomew's, 1; S. Mason, St. Bartholomew's, 2; A. McCullagh, Charing Cross, 3. Also ran: F. F. Eleves, Middlesex; C. J. B. E. Bitman, University; R. C. Leaming, St. Mary's; F. S. Batchelor and R. Balderston, Guy's. At one time Hay held a strong lead. In the last 300 yards Mason and McCullagh drew up, and entering the straight, Mason shot in front, but it was only for a few strides, as Hay put on a spurt, and won a fine race by three yards, McCullagh tiring at the close, being twelve yards further off. Time, 2 min. 1⅕ sec. —a record for Hospital sports.

PUTTING THE SHOT.—Holder, C. Rolfe, London; distance, 35ft. 2½in. Record, W. G. West, St. Bartholomew's, 38ft. 3in., 1889. F. W. Bennett, St. Bartholomew's, 34ft. 5in. 1; J. S. Mackintosh, St. Bartholomew's, 34ft. 4in. 2; E. N. Scott, Guy's, 33ft. 7in. 3. Also competed: H. Charles, Middlesex; C. C. Bullmore, University; M. Breton, St. George's; A. Arkle, St. Thomas's.

120 YARDS HURDLE RACE.—Holder, P. R. Lowe, Guy's; time, 17 sec. Record, J. G. Graveley, Guy's, 16¾ sec., 1877. Heat 1: H. N. Coltart, St. George's, 1; C. J. Armson, Middlesex, 2. Time, 18⅕ sec. Heat 2: J. Johnson, St. Bartholomew's, w.o. Heat 3: P. R. Lowe, Guy's, 1; W. R. Woodbridge, St. Bartholomew's, 2. Time, 17⅜ sec. Final Heat: J. Johnson, St. Bartholomew's, 1; P. R. Lowe, Guy's, 2; H. N. Coltart, St. George's, 3; W. W. Woodbridge, St. Bartholomew's, 0; Johnson always had a trifle the best of it with Lowe and won a pretty race by two yards. Woodbridge struck the last obstacle, and Coltart finished third. Time, 16⅜ sec.

220 YARDS.—Holder, H. T. Bell, Guy's; time 23⅕ sec. Record, H. T. Bell, Guy's, 22⅜ sec., 1892. Heat 1: N. J. Roche, Charing Cross, 1; H. W. Collis, Guy's, 2; Heat 2: H. T. Bell, Guy's 1; J.V. Worthington, London, 2; Heat 3: C. V. Cornish, St. Bartholomew's, 1; J. Johnston, St. Bartholomew's, 2. Final Heat: C. V. Cornish, 1; H. T. Bell, 2; J. V. Worthington, 3. Also ran: H. N. Collier, Guy's; J. Johnston, St. Bartholomew's. At one time Bell looked like repeating last year's victory, but sixty yards from home Cornish made a grand effort, and getting in front he won, amid much cheering, by four yards; five yards divided the next two, but the others were close up. Time, 23¼ sec.

FIVE MILES BICYCLE RACE.—Austin Woods, Guy's, 1 H. J. Millbank Smith, Guy's, 2; A. S. Bruzand, London, 3. Smith started with his jacket on (!) and getting rid of it cost him the race, as in throwing it off after going half-a-mile it caught the gearing of the behind wheel, and he had to stop before it could be disentangled. This lost him quite three-quarters of a lap. Nothing daunted he went in pursuit of the leaders, and slowly made up leeway. Woods drew out from the rest, but he could only win by twenty-five yards at the finish, while Bruzand was nearly a lap behind the second man. Time, 15 min. 24⅕ sec.

HIGH JUMP.—Holder, H. T. Bell, Guy's. Height, 5ft. 8in. Record, H. T. Bell, Guy's. Height, 5ft. 8in. 1893. S. F. Smith, St. Bartholomew's, 5ft. 5½in., 1; H. T. Bell, Guy's, 5ft. 4½in., 2. Six others competed. Smith afterwards cleared 5ft. 6½in.

THROWING THE HAMMER.—Holder, E. N. Scott, Guy's. Distance, 89ft. 5in. Record, J. E. Frazer, St. Bartholomew's. 93ft. 10in. in 1890. E. N. Scott, Guy's. 85ft. 1in., 1; F. W. Bennett, St. Bartholomew's, 82ft., 2; H. Charles, Middlesex, 79ft. 1in., 3; W. H. Kenrick, London, 0; F. H. S. Hutchinson, London, 0; J. S. Mackintosh, St. Bartholomew's, 0.

ONE MILE CHALLENGE CUP (presented by Guy's Hospital, 1870).—Holder, H. A. Munro, Guy's; time, 4 min. 41 sec. Record, H. A. Munro, Guy's; time, 4 min. 34⅕ sec. H. A. Munro, Guy's, 1; R. C. Leaming, St. Mary's, 2; F. F. Eleves, Middlesex, 3. Also ran: H. W. Dudgeon, Guy's; M. A. Smith, Charing Cross; L. S. Gaskell, London; F. J. Caine, St. Mary's: S. A. Lucas, St. Thomas's; H. Mundy, St. Bartholomew's; N. A. Cholomeley, St. Bartholomew's; E. S. D. Dewdney, King's; and R. H. Moore, Charing Cross. Munro soon had the measure of his opponents, and won easily at the finish by eighty yards. Moore ran second until about 300 yards from home, when he was beaten, and St. Mary's scored a second with Leaming twelve yards in front of Eleves; others close up. Time, 4 min. 36⅜ sec.

LONG JUMP.—Holder, H. T. Bell, Guy's, 20ft. 8in. Record, B. C. Green, St. Bartholomew's, 21ft. 3in., 1891. H. T. Bell, Guy's, 20ft. 7in., 1; J. W. Nunn, St. Bartholomew's, 20ft. 2in., 2; C. T. Armson, Middlesex, 19ft. 7in., 3.

440 YARDS CHALLENGE CUP (presented by G. N. Montefiore, Esq., Guy's, 1879).—Holder, F. S. Batchelor, Guy's. Time, 53½ sec. Record, T. A. Guinness, King's College, 51⅘ sec., 1880. Heat 1: C. A. McCullagh, Charing Cross, 1; F. S. Batchelor, Guy's, 2. Time, 55⅕ sec. Heat 2: C. V. Cornish, St. Bartholomew's, 1; S. Mason, St. Bartholomew's, 2. Time, 53 sec. Final heat: S. V. Cornish, 1; S. Mason, 2; F. S. Batchelor, 3; McCullagh, 0. Despite his previous exertions, Cornish ran splendidly, and won by five yards. Batchelor, who

at one period of the race looked like pressing the winner, finishing third four yards behind the second man. Time, 52⅔ sec.

THREE MILES CHALLENGE CUP (presented by Messrs. Mappin & Webb, 1887).—Holder, H. A. Munro, Guy's. Time, 15 mins. 54⅘ sec.. Record, H. A. Munro, Guy's, 15 min. 17⅕ sec. H. A. Munro, Guy's, 1; C. D. Edwards, Guy's, 2; P. F. Henry, Guy's, 3.; G. J. E. Pitmans, University, 0; D. L. Davies, University, 0; W. H. Kenrick, London, 0; A. Cooke, London, 0; G. R. Elwin, St. Mary's, 0; F. St. John, St. Mary's, 0. Munro went to the front after going once round, and making his own running to the end, he won by 550 yards; forty yards between the next two Guy's men. None of the others finished. Munro beat the previous record (his own) time at these contests by 1⅕ sec., the time being 15 min. 16 sec.

This brought the meeting to a close, the proceedings ending with the distribution of the prizes to the successful students by the wife of the President, Mr. H. A. Victor Horsley, F.R.S., F.R.C.S.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra amount of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps which have been sterilised by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

"A GUY'S MAN."—The growth is an epithelioma.

X., FAVERSHAM.—No tubercle bacilli were found.

C. D. M., BOURNEMOUTH.—No tubercle bacilli were found.

R. P., CARNARVON.—The growth is evidently a rapid one. The structure is of malignant glandular type, and shows rapidly-growing stroma. Would you kindly furnish us with details as to the primary growth.

W., SALISBURY.—The tumour consists of spaces contained in a stroma, which in the part examined is not of malignant type. The spaces contain hæmorrhagic deposits and many small cells, which are below 10 μ in diameter.

F. H. K., HUDDERSFIELD.—The growth is a large round-celled sarcoma.

H. L., SALFORD.—1. Æt. 38. The growth is that of an adenoma of the palate, which has become malignant and infiltrating. The epithelium at the edges has also commenced to infiltrate. 2. Æt. 12. Mixed sarcoma containing myeloid spindle and round cells.

R. J. R., HADLEY.—No tubercle bacilli were found in the sputum.

W. B., STREATHAM.—Tubercle bacilli are present in large quantities.

J. E., MIDDLESBROUGH.—Tubercle bacilli were found in the sputum.

M., ST. GEORGE'S, SHROPSHIRE.—No tubercle bacilli were recognised.

O., COVENTRY.—No tubercle bacilli were recognised.

G. J. W., MELTON MOWBRAY.—The spleen shows numerous infarcts, of some date, with accompanying congestion and deposition of pigment in the arterial areas. The gland sent contains a large amount of connective tissue, and at one edge is involved by a sarcomatous growth.

A. C. B.—The urine sent is alkaline, and contains some albumin. The precipitate shows tribasic phosphate, oxalates, epithelial cells, and a few pus corpuscles. The colouring matter belongs to the urobilin group. There is no hæmoglobin present.

We shall be pleased to examine a fresh specimen of this again, fee to be omitted. PATHOLOGIST.

Guy's Hospital Dental Department.

PRACTICE DURING APRIL, 1894.

Gold Fillings		194
Amalgam		420
Osteo		
Perm. G. P.		
Dead Teeth		93
Artificial Crowns		21
Scalings		36
Regulations		4
Dentures		18
Attendance for Extraction under Anæsthetics		700
,, ,, without ,,		647
Total		2133

PRACTICE DURING MAY, 1894.

Gold Fillings		300
Amalgam		419
Osteo		
Perm. G.P.		
Dead Teeth		90
Artificial Crowns		37
Scalings		22
Regulations		6
Dentures		20
Attendance for Extraction under Anæsthetics		992
,, ,, without ,,		500
Total		2386

Birth.

STARLING.—On July 5th, at Clifton Hill, N.W., the wife of Ernest H. Starling, M.D., of a daughter.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual subscription to the Gazette *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers, who may be desirous of having their numbers of the Gazette *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette,

AUGUST 18, 1894.

Pathological Jottings.

Syringomyelia with Joint Disease.

The patient was a man about 52, whose illness began some fifteen years previously, with pain in the arms and swelling of the shoulder-joints. Subsequently the shoulder and wrist-joints became spontaneously dislocated on each side, and in course of time other joints were similarly attacked. Button's eruptions appeared on the hands; the finger-nails were deformed, incurved and wasted; while sensation in respect of heat, cold and pain (but not touch) became much impaired. There was also marked atrophy of the muscles of the upper extremities. Death resulted from cerebral softening, due to embolism, and the autopsy revealed dilatation of the central canal of the spinal cord in the cervical and upper dorsal regions. This change had destroyed the ganglion cells in the anterior cornua, and so produced trophic lesions and deformities in the arms.

Dissection showed that there were old dislocations of both wrists, left shoulder, right thumb, and outer end of right clavicle. The changes in the shoulder and wrist-joints were those of osteo-arthritis. As regards the shoulder-joint, the head of the scapula was worn away in front, and a new joint-cavity existed upon the neck of the bone beneath the coracoid process. The head of the humerus was also much deformed, flattened, and worn away, and what remained of the articular cartilage was fibrillated and nodular. The interior of the new joint-cavity was covered with villous and polypoid processes, and there were additamentary bones in its wall. The right wrist-joint was enlarged, and presented a subluxation of the carpus inwards and forwards. The surface of the carpus was moulded to a compensatory buttress of bone upon the anterior border of the radius. By destruction of the triangular fibro-cartilage, the wrist-joint communicated freely with the inferior radio-ulnar articulation, and the interior of this large cavity was covered with villi and synovial fringes. At the back of the joint the extensor tendons were displaced by a bulging of the capsule. The tendon of the extensor carpi ulnaris formed a part of the capsule; the synovial lining of the wrist being prolonged upon the tendon for some distance. The enlargement of the capsules in both instances, the dislocation, and the marked erosion of articular surfaces are, like the osteo-arthritis, associated with ataxy, known as Charcot's disease. The anterior cornua being affected in each instance, the arthritis of ataxy and the arthritis of syringomyelia are clinically and pathologically the same disease. Dr. Alexis Thomson points out, in an excellent review of the subject, that joint lesions are on the whole more frequent in syringomyelia than ataxy, and chiefly affect the upper limb, because the lesion in the cord is generally in the cervico-dorsal region. He also records a typical case of syringomyelia in which the right shoulder was affected, the upper end of the humerus being worn away and the adjacent muscles atrophied.

Wanted—A Diagnosis.

A young woman, aged 27, came under observation for pain in the left loin and great frequency of micturition. Three years previously she had a suppurating gland in the neck, and, as that healed, pus appeared in the urine, and has done so for two years. Urine always acid, and otherwise normal. Loss of flesh. Temperature irregular. Bladder sounded for stone, but nothing detected. Vaginal examination showed nothing abnormal. Under an anæsthetic, the right kidney seemed much enlarged, but when explored through the loin, it was found to be normal in appearance, though large. As the symptoms persisted after the wound was healed, the left kidney was explored and removed, because it was pale and friable. Histologically, however, it was free from disease, and normal in size and shape.

Acute Tuberculosis of Testis.

A clergyman, aged 23, was quite well, when, without injury or other known cause, the right testis became intensely painful and enlarged. In spite of treatment, at the end of two months suppuration took place, and an abscess burst through the scrotum. A week later the testis became extruded from the scrotum. In this condition the patient came under observation. The testis was found to be covered with granulation tissue, and about four times the size of the left organ, which appeared healthy. The organ was removed by operation, and a rapid recovery ensued. The spermatic cord was healthy. Further enquiries elicited the fact that the patient had married one month before the trouble began, and that the sexual act had never been satisfactory. There had been no urethritis, nor had he been exposed to the risk of it. When seen nearly three years after the operation, the patient was in excellent health, without sign of recurrence of the disease.

On examination of the specimen, the epididymis was found to be much enlarged, and stuffed with yellow masses of caseous tubercle. From this lines and nodules of tuberculous material could be traced through the mediastinum testis into the body, and many grey tubercles were also present. As the body of the gland protruded through the scrotum, its exposed serous surface was coated with a layer of granulation tissue one quarter of an inch thick, and in this were to be seen yellow caseous nodules.

An Apoplectic Ovum.

A robust married woman, aged 19, was suddenly attacked with severe pain in the abdomen when racing with some other young persons down a suburban street. She had had amenorrhœa for four months. On the second day a free sanguinous discharge began, and lasted until the eighth day, when, after the administration of an enema, a pyriform mass four inches in length was expelled from the uterus. The membranes were apoplectic, and the funis was recognised as a stump, but no embryo was found. Histologically, the mass showed typical chorionic villi embedded in much blood-clot.

T.

Three Cases of Disease of the Nervous System.

NOTES FROM A CLINICAL LECTURE BY DR. SHAW.

The text of the lecture was drawn from three cases in Clinical ward, which had one common symptom, namely, *defective power of locomotion;* and the lecturer said that he proposed to discuss the diagnosis of those diseases which gave rise to inability to walk.

In such diseases this symptom is frequently the first noticed by the patient, and may be the only thing which he complains of.

Inability to walk is nearly always due to disease, either of the nervous system or of the muscles. But exceptionally it is not so, and, when this is the case, there is generally but little difficulty in arriving at a correct diagnosis, although in some cases the history given by the patient of a previous illness, accompanied by *paralysis* of the legs, might be misleading. It must be remembered that the most common cause of such an illness, apart from nerve disease, is acute inflammation of the cellular tissues or joints, *e.g.*, *acute rheumatism.* There is yet one other class of cases, namely, those due to functional causes, *e.g.*, *hysterical paraplegia.*

The diseases where the nervous system or the muscles are affected may be divided into two main classes:—

1. Those produced by loss of power.
2. Those produced by loss of co-ordination.

As illustrating the fact that these two classes might be confounded, Dr. Shaw referred to the fact that years ago, before multiple neuritis was a recognised disease, cases of alcoholic paraplegia used frequently to be looked upon as locomotor ataxy, and gave rise to a mistaken idea that the latter disease was not uncommonly recovered from.

Differential diagnosis.—If the patient is in bed, the presence or absence of loss of power can be easily ascertained by asking patient to flex up his knee against the pressure of the hand. If there is loss of co-ordination, patient would not be able to touch either the hand held above the bed or a given spot on the opposite leg with the great toe, with the normal amount of precision, although the strength of his limb might be in no way impaired. If the patient is able to walk about, the presence of inco-ordination will be shown by the gait. Patient will walk with his legs widely separated, will lift his feet too high off the ground, and will bring them down with too much force. Also, on placing the feet close together and shutting the eyes, there will be a tendency to fall.

Inco-ordination will generally be found to affect the upper extremities as well, as shown by inability to touch the nose with the eyes shut, etc. In the first of the three cases, loss of co-ordination was present. It was that of a boy, æt. 16, who, being the subject of congenital talipes equinus, had always had some difficulty in walking, which had increased rapidly during the last few months, and had been lately associated with clumsiness in the movements of the hands. There was no history of a similar affection or of nervous disorder in any of his relations. His parents have had six other children, of whom four are living, two girls being older than the patient.

Loss of co-ordination may be due to:—

1. *Intra-cranial disease—cerebellar tumour.*—If there is cerebellar disease severe enough to give rise to inco-ordination, it will generally also give rise to one or more of the five Hippocratic signs of intra-cranial tumour, viz.:—Headache; vomiting; vertigo; optic neuritis; fits.

The case under consideration had none of these signs, and so cerebellar disease was dismissed.

2. *Spinal disease—sclerosis of the postero-external columns.*—This occurs in three diseases, in some of which the sclerosis affects other tracts besides the postero-external columns. They are:—

a. Locomotor ataxy, in which the main lesion is in the postero-external columns.

b. Ataxic paraplegia, where there is lateral as well as posterior sclerosis.

c. Friedreich's disease—in which there is sclerosis of the posterior, lateral and cerebellar tracts, as well as of others of minor importance.

In ataxic paraplegia, the lateral sclerosis asserts itself very definitely, as shown by the muscular rigidity and the increased knee-jerks. The above case does not present either of these symptoms, and so the diagnosis lies between *a* and *c*.

Friedreich's disease is also called hereditary ataxia, which is a bad name, because the disease is not necessarily hereditary, for although the first fifty-six cases published all occurred in nineteen families, yet nowadays many cases are recognised in which there is no family history of a similar complaint.

The following are the chief points of difference between locomotor ataxia and Friedreich's disease:—

1. *Age.*—Friedreich's disease is common in children, and is hardly ever seen for the first time after puberty. The opposite is the case in tabes.

2. *Ataxia.*—As shown by the fact that Friedreich's disease has been mistaken for chorea, the ataxia in this disease shows itself chiefly when the patient is trying to lie still; whereas, in locomotor ataxia, it shows itself chiefly when patient is trying to move.

3. *Defective articulation*, characterised by hesitation in speaking. This is seldom present in locomotor, but common in Friedreich's disease. It is not like either the staccato speech of insular sclerosis, or the slurring speech of G.P.I.

4. *Nystagmus* occurs in Friedreich's disease, but not in locomotor. It is usually slight, and only occurs when patient looks in such a direction as to put strain upon his ocular muscles.

5. *Sensory symptoms.*—In Friedreich's disease there is no loss of sensation, and the pains are said to be dull in character. The patient in question undoubtedly has, however, severe pains in his legs.

In the above case the age, the conditions under which ataxic movements occurred, slight defect of articulation, slight nystagmus, and the absence of anæsthesia led to the diagnosis of Friedreich's disease. The patient was then shown. The most obvious feature was the inco-ordination in walking and in moving his hands. He was also unable to stand so well with his eyes shut, although Gowers says that this is not usually so in Friedreich's disease.

N.B.—An account of another case which died in the Hospital, together with a description of the spinal cord, will be found in a contribution by Dr. Pitt to the Guy's Hospital Reports for 1887.

The second case was that of a child, æt. 8, who was sent up as a case of infantile paralysis, with some unusual features. The child was found to have paralysis of both legs, together with rigidity and increased reflexes and jerks. The condition suggested spastic paraplegia, and hence in a child spinal caries, which was found to be present.

The third case was that of a man, æt. 69, who complained of inability to get about and to perform his work. The striking point about him was the extreme muscular wasting, which was most marked in the hands; the

interossei and the thenar and hypothenar eminences having nearly disappeared. The wasting also affected the forearms, biceps and triceps. The pectorals were equally small, and the calves were very flabby. During examination, fibrillary twitchings were noticed.

Paralysis associated with wasting.—The great difference between mere wasting from disuse and those cases of paralysis with essential wasting, must be noted. If the wasting is out of proportion to the disuse it must be due to a lesion of the lower motor tract, either in or below the anterior cornu. Such a lesion may be:—

a. In the anterior horns.

There are two classes of cases characterised by a lesion in the anterior horns.

1. *Regressive paralysis*, which is also called infantile paralysis (although by no means confined to infants) or anterior poliomyelitis (though some think that it is due to hæmorrhages rather than to inflammation). Its onset is acute and accompanied by fever, soon followed by paralysis, which, at first more or less complete, gradually clears up, leaving a few muscles permanently paralysed.

2. *Progressive paralysis*—the consideration of which the lecturer left till last, as it was the diagnosis of the case in question.

b. In the anterior nerve roots—generally due to pressure from lesion of the meninges. Most characteristically seen in *chronic hypertrophic cervical pachymeningitis* affecting the arms, and leading to spastic rigidity of the legs.

c. In the nerves—multiple neuritis. The great distinction is that the nerves contain sensory and other fibres, as well as motor. Hence, there are usually sensory symptoms, *e.g.*, pain, tingling, numbness, etc., and more rarely evidences of vasomotor or trophic disturbance leading to œdema, or a bedsore, in a position not subject to much pressure, *e.g.*, the elbow or ankle.

d. In the muscles.—There are two primary diseases of the muscles.

1. *Pseudo-hypertrophic paralysis.*
2. *Essential atrophy.*

i. May be overlooked because either the hypertrophic stage is not present, or it has passed unnoticed. It usually begins in quite early life.

ii. May be difficult to diagnose from progressive muscular atrophy. The chief points of distinction are (*a*) that essential paralysis frequently occurs in several members of the same family, and (*b*) that there is a tendency for the facial muscles to be affected early in essential paralysis.

Progressive muscular atrophy. — Gowers considers *amyotrophic lateral sclerosis* to be merely one form of *progressive muscular atrophy*. It is at least noteworthy that in every case of progressive muscular atrophy in which a searching post-mortem examination has been made, lateral sclerosis in greater or less degree has been found to be present.

Hence cases of progressive muscular atrophy may be divided into two classes:—

1. Also known as amyotrophic lateral sclerosis, in which lateral sclerosis is marked, the chief symptoms being rigidity and increased jerks.

2. In which the atrophy of the anterior horns is the most marked, and the chief symptoms atrophy of muscles and absence of jerks.

The case was then shown, and the very wasted condition of the muscles of the hands and arms pointed out.

Notes on Dr. Shaw's Demonstrations in Pathology.

HEART.

Tricuspid. Long cord (1401[5]), probably congenital, produced no clinical effects.

Regurgitation.

(1) Dilated orifice (1390[50]), most often produced by chronic bronchitis and emphysema, also often by mitral stenosis.

(2) Defective valves (1401[26]). Not often affected in acute rheumatism, more often affected in ulcerative endocarditis. Perforation and large vegetations are the common forms. Shrinking is much more rare.

Obstruction.

(1) Stenosis (1401[13], 1401[20]). No specimen in the Museum without two at least of other orifices implicated.

(2) Mass of vegetation (1401[30]). Tricuspid orifice is also subject to congenital disease.

Pulmonary.

Four valves (1413[35, 40]). More than three valves is a congenital condition, less than three is pathological.

Regurgitation.

(1) Dilated artery [223] very rare on account of the rarity of atheroma of pulmonary artery, though chronic bronchitis and emphysema may cause atheroma of pulmonary artery. Continued overfulness, due to mitral stenosis, may cause dilatation, as in the specimen.

(2) Defective valves (141[53, 60, 61]). Much commoner in ulcerative than in simple endocarditis.

Stenosis (1413[46]). Generally congenital.

Hypertrophy of the Heart.

Increased weight is the best test. Thickness of walls depends much on rigor mortis. In regard to the auricles, the rigidity (or capability of standing up and not falling together) on section is a test.

(*a*) General. Chronic interstitial nephritis (1389[30]): with arterial degeneration: hard work.

Adherent pericardium (1437[20]).

Fibroid heart (1324[29]). In fibroid heart there is sometimes a compensatory hypertrophy of the remaining healthy muscle.

(*b*) One-sided. Left. Bright's disease.
Right chronic bronchitis and emphysema (1391[80], 1392[15]).

(*c*) One cavity. Cause, valvular disease, especially stenosis.

Dilatation of the Heart.

(*a*) Primary where there has been no preceding hypertrophy. Causes, anæmia, fatty and fibroid heart, acute Bright (1394[27]).

(*b*) Secondary. See hypertrophy. Cause, valvular lesions, and especially regurgitation.

Thrombosis { 1395[80, 81, 86, 95] / 1387[50]

Congenital Heart Disease.

1. *Defects of Development.*

Ectopia cordis (1379[25]).

Deficient ventricular septum (1379[50], 1382[16]): generally deficient at the upper part; sometimes so much deficient as to produce a single ventricle, as in 1382[64].

Perforated (1328[20]), produced by ulcerative endocarditis.

Open foramen ovale (1384[46]). Common to slight extent without producing symptoms.

Open ductus arteriosus (1383[60], 1382[20]).

Transposed aorta and pulmonary artery (1385[50]).

Aorta derived from pulmonary artery (1380[40]).

Malformed valves. See supra.

2. *Intra-uterine Carditis.*

Narrow pulmonary artery (1382[48], 1413[75]).

Closed pulmonary artery (1379[10]).

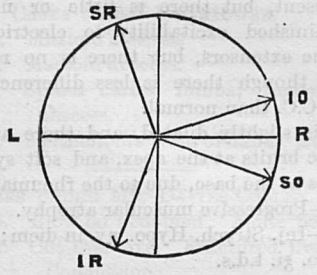
Endocarditis is undoubtedly transmitted from mother to child in utero; the right side is the most often affected, explained by the fact that the right side does most work in the fœtus.

Generally the pulmonary artery is affected owing to arrest of growth following inflammation.

It is generally associated with other malformations, *e.g.*, deficient ventricular septum.

Erratum.

In the diagram given in Dr. Pitt's clinical lecture on Oculomotor Paralysis, in the last number, the superior and inferior oblique muscles were transposed; the subjoined is the corrected diagram:—



Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Philip	32.	Angina pectoris. ? Atheromatous aorta.
	36.	Aortic stenosis and regurgitation.
Stephen	5.	Aortic stenosis and regurgitation. Mitral regurgitation.
	8.	Mitral and tricuspid regurgitation.
	16.	Mitral regurgitation
	19.	Aortic and mitral regurgitation. ? Dilated aorta.
	21.	Aortic stenosis and regurgitation. Mitral regurgitation.
	24.	Mitral stenosis and regurgitation.
Mary	1, 26, 34.	Mitral regurgitation.
	5, 11 25.	Mitral stenosis and regurgitation.
	49.	Mitral stenosis and regurgitation. Tricuspid regurgitation.

Nervous System.

Philip	24.	Paralysis left third nerve.
	35.	Cerebral tumour. Optic neuritis.
	39.	Friedreich's disease.
Stephen	3.	*Post-diphtheritic paralysis.*
	6.	Right hemiplegia. Syphilitic.
	12.	Cerebral tumour.
	17.	Myelitis.
	21.	Aphasia.
	30.	Paralysis agitans.
	33.	Progressive muscular atrophy.
Mary	8, 23, 30.	Chorea.
	9.	Paralysis agitans.
	13.	Right hemiplegia.
	50.	Alcoholic peripheral neuritis.

Alimentary System.

Philip	14.	Dysentery.
	17.	Carcinoma of pylorus.
	28.	Recurrent diarrhœa. ? Cause.
	34.	Tubercular peritonitis.
Stephen	39.	Carcinoma of pylorus.
Mary	17, 45, 29.	Gastric ulcer.
	2, 30, 33.	Cirrhosis. Ascites.
	21.	? Cirrhosis. Perihepatitis. Localized peritonitis.
	7, 35.	Typhlitis.
	38.	Carcinoma pylori.
	32.	Enterica.

Genito-urinary System.

Philip	8, 50.	Chronic tubal nephritis.
	5.	Chronic Bright's disease.
Stephen	4.	Chronic tubal nephritis.
Mary	4.	Tubal nephritis. Lardaceous disease.

Respiratory System.

Philip 38. Right pleurisy.
Stephen 16. Bronchitis and emphysema.
Mary 18. Bronchitis.
24. Left pleuritic effusion.
Philip 7, 32.
Stephen 28.
Mary 27, 34, 41. } Phthisis.

Miscellaneous.

Philip 33. Gout.
3. Mediastinal tumour.
18. Enlarged liver and spleen. Albuminuria.
Stephen 7. Gout. Mitral regurgitation. Hypertrophied heart.
13. Pyrexia.
27. Hodgkin's disease.
46. Epistaxis.

Case under Dr. Goodhart.

Philip.

3. W. B., æt. 59. Admitted for difficult breathing, giddiness, spitting of blood, and cough. Always healthy till a year ago, when he first began to suffer from bronchitis. At times has suffered from cough and hæmoptysis. Has lost weight. Least exertion causes difficulty in breathing; if any exercise is taken on, if patient stoops forward his face becomes blue, and he is seized with an attack of giddiness. Patient has a drawn and anxious expression. Superficial veins in chest and abdomen dilated; blood-stream downwards; slight fulness and pain over right clavicle. Temperature of arms vary, right generally being the colder; pulse compressible, no variation in the two sides; ears blue. Dulness over the front of right side of chest, which extends from right border of sternum to anterior fold of axilla; left side chiefly used in respiration; deficient entry of air on right side. Right vocal cord paralysed; left pupil larger than right; no bruit heard. Great deal of expectoration. Urine normal. No specific history. No improvement under Pot. Iod. and Mercury.

Cases under Dr. Hale White.

Mary.

9. S. R., æt. 68, seamstress. Admitted July 25th for tremors. Phthisical family history. She was badly burnt during infancy in the right axilla. Used to suffer from neuralgia, which was cured by extracting all her teeth. She has had two children, both living; her labours were very difficult. Four years ago she lost a favourite grandchild, and it was then the tremors commenced in her right foot, and gradually spread to the leg, right arm, and head.

Condition on admission.—There are rhythmical tremors of the right arm and leg, head and tongue, while the rest of the body is unaffected. There is marked paralysis, with some contraction and rigidity of the right hand and arm. Tremors regular in time and excursion, and diminished when any voluntary effort is made. There is no nystagmus or change of voice; no flushing or perspiration on moderate exertion; and no affection of progression, but the right arm and hand are held in the characteristic position of flexion, inward rotation and adduction to the middle line. The heart has presystolic and systolic apical bruits.

Diagnosis.—Paralysis agitans.

Remarks.—Treatment is of little avail. Life is but little shortened by it. This case is uncommon in its commencing in the leg, in being so hemiplegic, and in the tongue being affected. This patient illustrated very well the late age at which paralysis agitans comes on, that the tremor is fine, regular, continuous during rest, and that it ceases for a moment or two on attempted movement, that it is usually more marked in the arm and leg on one side than in the arm and leg on the other. The hand is usually most affected; tremor of the head is not common, and that of the tongue, which this case showed, is very rare. Paresis is always very marked. The rigidity giving the characteristic attitude is usually present, but this patient only showed it in her arm. She did not exhibit the anxious expression, the slow speech, or the sensations of heat and cold.

Stephen.

33. H. W., æt. 16, greengrocer's assistant. Admitted July 25th for wasting and weakness after rheumatic fever. His family history is good, and he enjoyed perfect health till the middle of May, when he developed rheumatic fever, which affected a large number of joints. During convalescence, about the middle of June, he felt slight tingling sensations and noticed he was losing flesh all over. This loss continued though the tingling ceased.

Condition on admission.—There is very marked uniform wasting of absolutely all the muscles connected with the limbs, including those arising from the trunk, and all scapular muscles. Those of the spine are but slightly affected, while the intrinsic muscles of the abdomen and thorax, together with those of the face and neck, are unaffected. Measurement round biceps, 6½ inches; round calf, 9½ inches. The dynamometer shows 40 pounds and 30 pounds for right and left hands respectively. There is no deformity of hand or foot; coldness and lividity of the limbs, and fibrillary contractions are absent. The sphincters are unaffected, and there are no signs of progressive bulbar paralysis, or of interference with respiration. Sensation to touch and temperature is perfect. The reflexes are exaggerated, and ankle clonus is present, but there is little or no rigidity. There is diminished excitability to electricity, more marked in the extensors, but there is no reaction of degeneration, though there is less difference between A.C.C. and K.C.C. than normal.

The heart is slightly dilated, and there are systolic and presystolic bruits at the apex, and soft systolic and diastolic bruits at the base, due to the rheumatic fever.

Diagnosis.—Progressive muscular atrophy.

Treatment.—Inj. Strych. Hypo. ♏v. in diem; Massage; Mist. Acidi. Co. ʒi. t.d.s.

Remarks.—In this case the following points are of interest. The patient is unusually young; he suffered from the preliminary pain which soon disappears. The disease has, as is commonly the case, picked out the hand and shoulder muscles very markedly; but in the present patient the wasting of muscles is unusually extensive. The face and upper part of the trapezius are very rarely implicated. It is not uncommon in progressive muscular atrophy to find the reaction of degeneration but slightly marked. The exaggerated knee-jerks and ankle clonus are very important, and are often present in progressive muscular atrophy; they indicate the sclerosis of the crossed pyramidal tracts that is always found at post-mortems in cases of progressive muscular atrophy, which must be regarded as a disease the characteristic of which is a great tendency for atrophy of the motor cells of the central nervous system, most commonly those of the anterior cornua corresponding to the brachial plexus, hence the atrophy of arm and hand; next the other anterior cornual cells, hence the atrophy of the trunk and lower extremities; next the motor nuclei of the lower cranial nerves, hence the frequent association of progressive muscular atrophy with bulbar paralysis, well shown in a case in Stephen six weeks ago; and, lastly, the motor cells of the Rolandic area, hence the lateral column sclerosis.

It was suggested that the atrophy was due to arthritic changes of his rheumatic fever. This is quite a possible view, but the facts that point strongly against it are, that the atrophy and weakness was not noticed till a month after the rheumatic fever; that arthritic muscular atrophy always clears up with the improvement of the joint inflammation, unless that has been very long standing; that although occasionally arthritic atrophy may be associated with slightly exaggerated knee-jerks, yet they do not persist; that the arthritic atrophy is rarely so extensive, and would be most evident in connection with those joints likely to be affected by rheumatic fever, but this atrophy had exactly the distribution of progressive muscular atrophy; that the case was not one of neuritis, was shown by this last reason, by the absence of sensory symptoms, and by the presence of increased knee-jerks and ankle clonus.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	—.	Mastoid abscess.
	9.	Mastoid abscess.
Charity	Cot.	Spinal caries, lumbar region. Psoas abscess.
	—.	Epithelioma palm of hand. Amputation.

Cases under Mr. Davies-Colley.

Cornelius	13.	Blow on abdomen. Acute peritonitis.
	12.	Cut over eye. Fractured frontal bone. Concussion.
Lydia	19.	Irreducible femoral hernia.
	Cot.	Child of 9 months old with perineal abscess, which opened into rectum.
	22.	Pulpy knee.
	2.	Vesical calculus.
	5.	Mastoid abscess.
Luke	5.	Enlarged glands in groin. Sinus.
	7.	Perineal abscess.
	11.	Enlarged prostate. Hæmaturia.
	7.	Strangulated inguinal hernia.
	18.	Suppurating bursa patellæ.

Cases under Mr. Lucas.

Lydia	10.	Congenital dislocation of hip. Double.
	Cot.	Congenital talipes equino-varus.
Job	22.	Hip-joint disease. Sinus.
	8.	Old fractured patella. Star-shaped fracture. Synovitis of knee-joint.
	25.	Tubercular glands in neck.
	18.	Mastoid abscess.
Charity	2.	Biliary fistula following cholecystotomy.
	3.	Retention of urine. Distended bladder. Cause not obvious.

Cases under Mr. Golding-Bird.

Martha	4.	Semilunar cartilage removed six months ago. Return of pain in knee.
Lazarus	20.	Hip disease.
	8.	Stone in kidney.
	21.	Inguinal hernia.

Case under Mr. Jacobson.

Dorcas	2.	Enlargement of thyroid right lobe. Left lobe previously removed.

Case under Mr. Symonds.

Job	11.	Spinal caries. Psoas abscess.

Case under Mr. Lane.

Dorcas	Cot.	Talipes varus.

Cases under Mr. Dunn.

Lazarus.	2.	Double hydrocele of tunica vaginalis. Left inguinal hernia. Strangulation. Operation.

Lazarus.

1. W. P., æt. 45. Admitted into Philip ward under Dr. Goodhart, for pain in abdomen and constipation, on July 24th. Patient had rheumatism three years ago. No other illness; bowels regular. While at work on July 20th, patient was suddenly taken with violent pain in abdomen in region of umbilicus; that morning bowels had been loose, but he had previously taken some castor oil. He went home to bed, and the pain became so severe that he was obliged to sit up in bed with his head between his legs. Until the morning of the 22nd he

vomited freely and was unable to keep any food down; since then there had been no vomiting. Bowels open well on 22nd.

On admission.—Patient was not extremely ill. Temperature 100; pulse 84.

Abdomen moved freely on respiration, and movements of intestine were perceptible through abdominal wall; there was a distinct swelling to left of umbilicus, to which patient referred all the pain. On percussion abdomen was tympanitic. There was thirst and loss of appetite.

Tongue very dry and cracked.

Urine dark yellow colour; acid; sp. gr. 1018; albumin 5 parts per 1,000; no sugar.

Dr. Shaw diagnosed intestinal obstruction; it was decided not to operate immediately.

25th. Patient was in great pain; abdomen markedly distended, very rigid, did not move on respiration; pain all over abdomen. Bowels opened by an enema.

Dr. Shaw and Mr. Dunn saw patient, and it was decided to perform an abdominal section at once. Patient was transferred to Lazarus.

Operation.—A. C. E. having been administered, Mr. Dunn made a median incision from about two inches above umbilicus to four inches below it. On opening the abdomen a considerable quantity of semi-purulent foul-smelling fluid escaped, and a piece of very distended large intestine was at once seen. On examination, Mr. Dunn found that the cæcum had become twisted on itself, and rotated somewhat over to the left side just below the left lobe of the liver, forming a well-marked volvulus. This was reduced, the cæcum being twice twisted on itself. The bowel was very congested, and some portions of it looked gangrenous. The reduced cæcum and part of the colon was then brought through the wound and punctured; quantities of foul flatus escaped at once, followed by liquid fæces. The abdominal cavity was irrigated, and the protruding gut, including the gangrenous portion, was stitched to the edges of the wound in the usual way. A bent glass tube, to which a length of india-rubber tubing was attached, was ligatured into the intestine, and iodoform ordinary dressing applied. In the evening patient seemed easier. Temperature 99·8; pulse 88; respiration 24. Liquid fæces were passed freely by the tube.

26th. Patient feels better, but has been coughing a good bit. Abdomen moves slightly on respiration, is not so distended, and does not give patient much pain. Pulse rapid and small; temperature 98·2. Diet, milk and eggs; brandy. Dressings were found to be soaked but not foul; tube firm, although bowel was found to be sloughing. I. M. H. gr. $\frac{1}{6}$, 9.30 p.m.

27th. Patient was sick twice during the night. I.M.H. gr. $\frac{1}{6}$, 9.30 a.m. Diet, brandy ʒss.; Liq. Strychninæ ɱiij. 3tis horis. Abdomen free from pain; no distension; moves on respiration. Patient was very sick again during the night, and on examination a coil of small intestine was found to have pushed its way through on the left side of the cæcum and the side adhesions were firm. Intestine was returned and firm pressure applied by bandaging.

28th. Abdomen was tense and much distended, scarcely moving on respiration. Temperature 97; pulse 120, just perceptible at wrist; respiration 32. During the day patient became much worse, and died at 3.50 during an attack of vomiting.

Autopsy.—Stomach and small intestines were distended. Part of cæcum and colon drawn through abdominal wall was sloughing; there was no general peritonitis. The hepatic flexure of colon was found to be united by adhesions of the great omentum to the descending colon and sigmoid flexure. Cæcum and ascending colon, as far as artificial opening, were extended and congested; one or two small superficial ulcers on mucous surface.

Kidneys.—Some tubal change.

The interest of the case is in the fact that volvulus of the cæcum is rare, the usual locality being in the sigmoid flexure of the colon; and that there was no evidence of peritonitis found, as to the cause of death.

A Case of Tetanus.

M. M., æt. 39, a married woman, was admitted into Miriam, under the care of Dr. Shaw, on July 12th, for lock-jaw.

There is nothing in her family history bearing on the case. About a fortnight ago she had toothache, and a small gathering in the lower jaw, but this very soon disappeared.

Her present illness dates from the 9th, on the evening of which day patient suffered from slight dysphagia; this caused her very little worry. The next morning she still had dysphagia, and in the evening there was spasm of the muscles of the jaw; she was, however, able to open her mouth. On the 11th the spasm of the muscles of the jaw became greater, when she called in a medical man. She was able to open her mouth for him to examine her throat. He ordered liniment to be rubbed in, and a mixture, which, however, was not taken, on account of the difficulty she experienced in the act of deglutition. To-day (the 12th) she has not been able to open her mouth more than about one-third of an inch. She has taken no solid food since the 10th, and nothing whatever for the last twenty-four hours. She has had no cut, scratch, bite or prick that she can recollect.

On admission.—There is spasm of the muscles of the jaw on both sides, causing marked trismus. The teeth cannot be separated more than one-third of an inch. The muscles of the neck, especially the sterno-mastoids, are rigid and painful. Difficulty is experienced in swallowing even small quantities of fluid. She com-

plains of slight stiffness in the muscles of the thigh. There is no rigidity of the muscles of the back, abdomen, or limbs. The facial expression presents nothing peculiar. Sensation unaffected. Cerebral functions normal.

Temperature is not raised; urine 1028, urea 2·9 per cent.

There is no swelling to be felt behind the jaw. The temporo-maxillary articulation appears quite normal.

Treatment and progress.—July 12th. Fluid diet ordered: Syr. Chloral, ʒi.; Pot. Brom., ʒss.; Aq. ad., ʒi. 4tis horis. There was no change in her condition.

13th. Trismus more marked. Syr. Choral, ʒii. 4tis horis. 4 p.m. Slight arching of back. Patient perspired freely. Fluids have been swallowed up to this time. Syr. Chloral ʒii. 3tis horis. 7 p.m.: Slight convulsions; opisthotonos more obvious. Swallowing caused respiratory spasm, possibly owing to the milk getting into larynx. It was therefore decided to feed her by a nasal tube. 12 p.m.: Nasal tube passed, and ʒiv. Syr. Chloral. Three ounces milk had passed down when there was a sudden respiratory spasm. Patient became extremely livid, and ceased breathing for about thirty seconds. The foot end of the bed was raised, and artificial respiration was resorted to. She very soon began to respire again. She immediately had general convulsions—opisthotonos, slight pleurothotonos, rigidity of limbs, and risus sardonicus. There were also clonic contractions of muscles of extremities. This lasted about two minutes, when she became quite quiet, and remained so for about twelve hours.

14th. At 6 a.m. she took nutrient enema ʒvi., Syr. Chloral ʒiv. per rectum. At 12 a.m. another enema was given, which was immediately rejected. At 2.30 p.m. $CHCl_3$ was administered for the purpose of feeding her. Great difficulty was experienced in relaxing spasm, reflex contractions being easily obtained when the conjunctiva was quite anæsthetic. It was found impossible to pass a soft tube, but one slightly more rigid easily went down. Milk, ʒx., two eggs, Syr. Chloral, ʒiv. given. This was all retained, although she had a tendency to vomit. The carious stump of a lower molar tooth was extracted. At 4 p.m., Morphia gr. ¼ injected, and again at 9 p.m. The spasm of the jaw is distinctly less; there is still slight rigidity of limbs and arching of back. She has taken to-day Syr. Chloral ʒx by the mouth and ʒiv. by the rectum. Morphia, gr. ½, subcutaneously.

15th. 3.15 a.m.: Convulsions. Temperature 101·8: pulse 120; respiration 40. Spasm soon passed off. 3.45 a.m.: convulsions again came on. Chloroform inhalation just commenced, when patient's arms became rigidly extended, the convulsions increased, and death took place in expiratory spasm. Artificial respiration was resorted to, but with no result.

Autopsy.—Heart, kidneys, liver and spinal cord all normal. Patches of collapse in lung; large gall-stone impacted in cystic duct.

Notes on Small-Pox.

By Stephen Floyd, M.B. Lond.

Although I cannot pretend to advance any new ideas on the symptoms or treatment of small-pox, a short account of the difficulties met with by myself as a beginner may be useful to the readers of the Gazette.

The diagnosis of a slight case of small-pox is by no means easy, especially if it is an isolated one. If you are doubtful, have the patient stripped and examine all over. Look especially carefully amongst the hair; feel the spots without looking at them, and see if they are shotty. Ask the patient if he has had good health up till the spots appeared. If the disease is really small-pox he will nearly always complain of previous pain in the back, headache or vomiting. If he says this occurred three days ago, you have very good grounds for having him isolated.

According to Curschmann, varicella may be practically excluded if the patient is above fourteen. This statement, however, is absolutely false, as varicella is sent down to the ships in mistake more often than any other disease.

Some of the papular forms of syphilis are very hard to separate from small-pox.

Some kinds of insect stings, especially those of the mosquito, look very like the early rash; as a rule, however, they itch extremely.

Mosquitoes are very abundant at the ships just now. Their stings show great variety, from a simple erythema up to a pemphigus-like eruption. They are usually noticed in the morning on the parts of the body which have been exposed during the night.

The severest, like the mildest, cases are often hard to diagnose. An initial erythema sometimes extends over the whole body, and looks exactly like a scarlet fever rash.

The initial erythematous rashes do not seem to be very common in the present epidemic—I have seen four in about 150 cases. One of these, case IV., was very interesting, as it closely resembled an ordinary hæmorrhagic case.

An old lady came in recently with a mild attack of variola, but with her legs covered with a copious hæmorrhagic rash. She was suffering from rheumatoid arthritis, so I thought this might be a case of a rheumatoid rash. She has got well and is to go out in a few days.

The presence of variola is no bar to that of other specific fevers. I have seen cases complicated by measles, scarlet fever, and erysipelas.

We have had two well-marked cases of parotitis in the Wards recently; also two of phlebitis, and one of iritis. The umbilication of the pocks is very often absent and is of little value as a diagnostic symptom.

The treatment is mainly symptomatic. Sponging is very grateful to the patient, and will often reduce the temperature three degrees.

A very useful gargle for the sore throat is—

Pot. Chloratis	... ...	℥ss.
Acid Hydrochlor. Conc.	...	℥iii.

allow to stand and add water to five pints.

A pleasant emulsion for painting on the pustules is made by mixing olive oil with an equal bulk of lime-water.

Most of the corneal ulcers heal well under the ordinary treatment.

Corneal ulcers are very common. In obstinate cases the actual cautery gives good results, but often sets up a violent conjunctivitis.

The great painful œdema of the lids is relieved by a small ice poultice.

DISCUTE SMALL-POX.

CASE I.—Copious papular rash, becoming vesicular; miscarriage; cellulitis; ischio-rectal abscess.

A. G., æt. 38. Admitted May 8th. Vaccinated in infancy, two indistinct cicatrices: total area, forty-three inches; quarter foveated.

May 19th. To sit up.

22nd. Upper part of right forearm on flexor surface much swollen and tender; whole arm œdematous. Swelling extends half-way up the upper arm.

23rd. $CHCl_3$ given, and six incisions made. No pus, but a great quantity of watery blood escaped.

June 1st. Left arm similarly affected; two incisions made.

11th. To get up.

17th. Patient miscarried; fœtus about five months; very decomposed, and covered with small-pox eruption.

19th. An ischio-rectal abscess opened on left side.

27th. Patient quite well; to go out in a few days.

CASE II.—Alice V., æt. 4. Variola with scarlatina.

Admitted June 13th. No signs of vaccination. Profuse pustular eruption.

June 18th. Temperature normal.

19th. Profuse pink lenticular rash. Temperature, 104. Child has no sore throat; tongue clean; upper cervical glands enlarged. ? Rötheln.

20th. Rash looks more like scarlet fever, but is still very patchy; slight sore throat.

22nd. Rash gone; temperature normal; very slight desquamation on sides of neck. *Urine*, no albumin.

28th. Began to peel profusely. Removed to Gore Farm.

CASE III.—Alice B., æt. 31. Variola with diphtheria.

Admitted June 1st. Scanty rash, chiefly papular.

June 16th. Patient feels quite well; to be discharged June 21st.

June 17th. Acute swelling, both tonsils; temperature, 104. No signs of membrane anywhere.

19th. No albumin in urine; temperature, 103. Uvula pushed forwards between enlarged tonsils; no follicles on tonsils. ? Diphtheria.

29th. Much better; temperature normal.

30th. Patient complained of food passing down nose when she swallowed. Tonsils quite small. The uvula is drawn over to right side when patient says "Ah."

July 2nd. Discharged. Paralysis of palate much less.

CASE IV.—Primary petechial rash, followed by profuse but discute eruption.

S. H., æt. 23. Admitted June 20th. Raised measly initial erythema over extensor surface, hands, and arms, scattered two-thirds of the way up the upper arm. Present also on extensor surfaces of feet. Petechial initial rash of usual distribution on trunk, thick on abdomen and groins, and more scanty on chest and in axillæ. This rash extends across the back, but is more scanty there.

June 21st. Two considerable hæmorrhages on buttock.

22nd. Papular eruption just beginning on forehead.

23rd. Hæmorrhages on buttocks nearly faded.

July 6th. Patient quite well; to go out in a few days.

This case illustrates the fact that when subcutaneous hæmorrhages occur in the early rash the case need not terminate fatally, as it almost invariably does if hæmorrhages occur in the specific eruption. I am not speaking of hæmorrhages into the pocks but between them.

Case of Missed Hare-Lip.

BOY, æt. 4½. On eversion of the prolabium a slight notch is seen on the right side, in the usual situation. (In the photo this is somewhat displaced, owing to the

posture of patient). There is a marked thinness of the tissues of the lip along a line running upwards from this notch. There is no cicatrix. That the sluggishness in the developmental process was not confined to the lip is hinted at by the fact that the right lateral incisor was erupted as late as four years of age, and then in a bad position—an unusual condition in the temporary dentition. The models may be seen in the Museum at the Conservation Room.

Passim.

The next Gazette will appear on September 8th, and in the following issue—a fortnight later—a new departure is to be made this year, as it is intended to produce, so far as possible, a Students' number. Apart from a portion of a Clinical Lecture on "Surgery," which Mr. Bryant has kindly allowed us to publish, there will probably be no other "shop" in the Journal, which will contain complete but brief accounts of the Hospital Institutions, Lecturers and Lectures, and it is hoped will form a perfect *vade mecum* to the embryo Guyite.

The meeting held in the Anatomical Theatre, on Thursday, July 26th, was one which will be remembered with joy, mingled with sorrow, by many of those present, as it was the occasion chosen for the presentation of a chiming clock, mounted in brass, to A. H. Tubby, Esq., M.S., on the cessation of his active term of office on our School Staff. The presentation took place in the form of an address, read by Mr. V. E. Collins, to which Mr. Tubby suitably and feelingly responded.

In our last issue we omitted to note that P. R. Lowe gained the second place in the hurdles at the Amateur Championships Meeting, being beaten by G. B. Shaw by three yards, in the fast time of $16\frac{3}{5}$ sec. Mr. Lowe is also to be congratulated on the tact and energy with which, as Hon. Secretary, he carried out the United Hospitals' Meeting at Stamford Bridge.

At the Kildare Athletic Club's Sports on the 21st ult., H. A. Munro ran third from the 60 yards' marks in the 3 miles race, his time being 14 min. $58\frac{4}{5}$ sec.

C. E. Hibbard is to be congratulated on his successes in the New Brompton Football Club Athletic Sports, when he obtained three first prizes, one second, and one third prize in the various forms of athletics.

We call attention to a paragraph in another column relative to the issue of the 1893 volume of Reports, which, though bulkier than any of its predecessors, is still cram full of interesting papers.

We hope we may not be compared to the Tortoise (of fable notoriety) in at length extending the hand of congratulation to those men who obtained Honours in the recent Intermediate M.B. Especially to be extolled is the name of Mr. V. E. Collins, who quite upheld the Hospital prestige in bringing the Gold Medal for Physiology for the third successive year back to Guy's.

The number of applicants for the Dresserships in the Throat Department has lately been very large, and as this number is likely to be still further increased when men under the five years' regulations have reached their fifth year, the Medical Council have determined to make some alterations next session. The total number of Dresserships will be increased from four to eight, and the system of extension at present in force among the Surgeons' Dressers will be introduced. By this means some of the Dressers will have had three months' previous experience, which will be of value both to the Surgeon and to their less experienced colleagues.

At the same time a new appointment will be made of Clinical Assistant in the Throat Department. This officer will be a qualified Student who has already held the appointment of Dresser in the Department. He will, in the first instance, be appointed for six months, but will be eligible for re-appointment. With so much skilled assistance it is probable that this

rapidly growing Out-Patient Department will become more popular than ever.

We are requested to announce that the Hospital Library will be closed from the 13th to the 31st of this month.

We are asked to call attention to a notice lately posted in the Colonnade inviting applications for the post of Assistant Demonstrator of Bacteriology. We understand that the holder of the appointment will be required to devote the whole of his time to the work; he will, therefore, presumably, be a qualified man. His duties will chiefly be connected with the examination of the large amount of material now sent from the Wards for bacteriological investigation, but he will also assist in the course of Demonstrations, which are in future to be given twice a year.

It is our painful duty to record the sad death, from phthisis, at Bournemouth, of Mr. E. E. S. Silver, of Chislehurst, whom many will remember as Dresser to Mr. Durham in November to January, 1892–3; he entered the Hospital in October, 1887, and was preparing for his Finals when seized by his last illness.

Invitations for the annual House Dinner, to be held in the Dining Room on October 1st, will be sent to every member of the Clubs' Union, but we are reminded that those who would give themselves the pleasure of meeting Mr. Durham, as Chairman of the Dinner, should make early applications for tickets, which are to be limited in number to 110.

As will be gathered from the averages of the cricket eleven on another page, W. I. Hancock has quite upheld his batting form during the season, and again wins the Trophy, with an average of 41·22; J. H. Joyce's average was higher, but he had not played in a sufficient number of matches. E. T. Shorland heads the bowling department with 49 wickets, at the cost of 10 runs each, so securing the Bowling Trophy, and we must congratulate him on his return to form, this being his best season since he came up.

As this is almost our last appearance during the present School year, it may not be out of place to review briefly our position in the world of Hospital Sport. Early in the year we re-asserted our superiority in cross-country running, when in the race for the Cup our three representatives were the first home. Though we once more failed to snatch from St. Thomas's the Blue Ribbon of the year—the Rugby Football Cup—we were in some measure consoled by gaining the Association Cup, which has not adorned our walls since 1886. Thomas's again secured the Tennis Cup after a fair struggle, and were also successful in the Shooting Competition, this time, however, by a much narrower margin; and, to turn to events of much later date, everyone knows how Bart.'s robbed us of the Athletic Shield, and how we have for the fifth successive time earned the title of Cricket Champions.

From the foregoing remarks it will be seen that we now hold the Cricket, Association Football, and Cross-country Cups, while the Rugby Football, Tennis and Shooting Cups are held by St. Thomas's, and the Shield has once more returned to Bart.'s.

Our ardent hope is that during the coming year we may retain the Cups we have, and secure those we have not; and—as it seems highly probable that a greater number than usual of our best men will be unavailable next season—we would, if possible, stimulate those who remain with us to greater and more regular effort in the field of Sport, thus upholding the honorable fame of our School in every possible manner.

Poisonous Symptoms caused by eating Preserved Brawn.

On June 12th, 1894, a family, consisting of seven persons, of ages varying from 20 to 40, partook of some brawn for supper, about nine p.m. The brawn had been preserved in a glass mould, and no unusual odour was noticed; the only peculiarity in taste was that it was very salt. On waking next morning, all complained of feeling ill; two of the family were very sick within a short time, and they experienced no other ill effects; another, a man, aged 28, was sick, and suffered from sore throat, pains in the legs, and general malaise throughout the day. His wife was sick also, and had similar pains in the legs. She had an eruption of small whitish vesicles on the mucous membrane of the mouth and throat, which lasted for two days.

The patient most seriously affected was the housemaid—a girl aged 20—who, being, as she said, fond of salt food, ate very largely of the brawn. When she woke next morning, she felt heavy and stupid, and had aching sensations in the legs. She was not sick till about one p.m. When seen at six p.m., her temperature was 99·2 F., pulse 90, and she looked flushed and heavy about the eyes. Scattered over the mucous membrane of the mouth and throat were several vesicles of whitish colour, about the size of pins' heads.

I did not see her on the 14th, but on the 15th was sent for, because a rash had appeared. The eruption affected nearly the whole surface of the body, and consisted, on the arms, back, chest and abdomen, of irregular-shaped rose-coloured blotches, the largest three by one and a half inches, the smallest about the size of a shilling, not raised above the level of the surrounding skin, and fading on pressure. A similar eruption covered the thighs. Over both surfaces of the legs a different rash presented itself; here the patches were circular in shape, more distinctly marked at the edges, and consisting of a peripheral area of almost scarlet colour, and a central area of pink colour; in size the patches varied from that of a five-shilling piece to that of a shilling. The eruption as a whole caused very little itching. The face was flushed, but presented no distinct eruption; the tongue coated white; pulse 102; temperature 101·2. Lotio Plumbi was ordered to allay irritation; a mixture containing Pot. Chlor., Tinct. Cinchon. Co. and Mag. Sulph. and Ol. Ricini, ʒi. statim.

16th. Patient looks and feels much better. Pulse 72; temperature 98·2. Bowels open well. The erythematous blotches have faded considerably from the arms, trunk and thighs; the circular areas on the legs are still very distinct, the central part now pale pink, the peripheral bright pink and well marked. Sixteen of these areas were counted on the right leg, and twelve on the left. The vesicular eruption on the mouth and throat is disappearing.

18th. The rash has quite disappeared. Patient is very weak and pale; "feels as if she had gone through a long illness." Ordered a mixture containing Ferri et Ammon. Citrat. and Tinct. Nucis Vomicæ.

No analysis of the remainder of the brawn could be obtained, for to prevent it being eaten by any one else, it had been burned. The glass mould also had been washed when it was seen. On enquiry, no other persons had complained of poisonous effects from other samples of the brawn, of which several had been sold.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra amount of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps which have been sterilised by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

F. B., Swansea.—No tubercle bacilli were recognised in specimen sent.

H. D., Faringdon.—The specimen sent has the structure of an adeno-carcinoma with well-developed stroma. Kindly report the presence of any other growth in the patient.

A., Tunbridge Wells.—Tubercle bacilli present.

W. H. S., Newcastle.—Tubercle bacilli present.

C. B. B., Huddersfield.—Carcinoma mammæ.

C. P., Burton-on-Trent.—Tubercle bacilli present in small quantity.

G. F. H., Balham.—1. Specimen received on July 17th. No tubercle bacilli recognised. 2. Specimen received on July 18th. Tubercle bacilli present.

J. G., Tunbridge Wells.—Tubercle bacilli are present.

A. R. Martin, Rochester.—Tubercle bacilli are present.

A., Bournemouth.—No tubercle bacilli were found.

C. J. F., Woolwich.—No tubercle bacilli were recognised.

H., Northampton.—Many thanks for your report. The growth is a small-celled glioma of diffuse character.

A.—Tubercle bacilli were present in the sputum sent.

H., Sutton.—No tubercle bacilli were recognised.

E., Folkestone.—Membranes A, B, and C, contained the Klebs Söeffler bacillus.

PATHOLOGIST.

At the Sign of The Liar.

Having made up my mind to plump for our esteemed Surgeon and Teacher, Mr. Davies-Colley, who was a candidate for a seat upon the Council of the Royal College of Surgeons, I visited that respectable institution and recorded my vote. It was then about 2 p.m., and the poll was soon to close. After that there was a long interval, during which the President, arrayed in his official robes and seated before a huge box, fished out therefrom a voting paper and handed it to the secretary, standing by his side. The secretary in turn slowly read out the names upon it in a loud voice with a peculiar intonation of the last name, the monotony of which was most trying to delicate ears. So I escaped from the chamber and spent the time while waiting for the result of the poll in looking round a roomful of specimens which had been recently added to the College Museum. They represented a variety of subjects—zoology, botany, anatomy, osteology, and the like. Naturally, I was first attracted by the merely curious objects from which nothing was to be learnt, such as Baron Dimsdale's lancet. Quite an ordinary lancet was this relic, with a conventional tortoise-shell handle and shagreen case, but it had a history and that was enough. The Empress Catherine of Russia offered a large sum of money to any physician who would perform the operation of inoculating herself and son, the penalty of failure or injury to her person being death. Upon these terms no Russian or Continental doctor would undertake the job. At last Dr. Dimsdale went over from England, in 1768, and accepted the service. He was warned of the consequences of failure or injury, and taken to the grim place of execution; but nothing daunted, he carried out the operation with perfect success by means of this insignificant lancet. In gratitude the Empress loaded him with presents. He received a fee of £12,000, a pension of £500 a year for life, and the dignity of a Baron of the Empire. But that was not all, for just as he was embarking for his native land the Empress, with motherly solicitude, gave him an exquisitely painted small china pôt de chambre, saying that he might find it useful on his long voyage. That china pôt is still to be seen.

Near this lucky lancet was an equally lucky hook—an ordinary hook from a woman's dress. This had been swallowed by a child, and the terrified mother had administered a purge instead of a whipping. In due course the hook appeared, having captured in its transit a remarkable fish. Through both loops of the hook a long worm (like a garden worm) had dexterously threaded its body, until it had become firmly held and could neither go forwards nor backwards. Whether the worm was delivered alive or not is unknown, but that we have in this common article a valuable vermifuge for future use cannot be reasonably doubted. It reminds me of something I once saw at a farm in the south of England. In one corner of the farm yard was a w.c. for the use of the labourers, the door of which was often ajar. A certain young pig made his way into the establishment and closed the door; then being frightened because he could not escape, the animal must have made frantic efforts to get through the only remaining aperture, for when my attention was called to it I found him quite dead, with his head and thick neck firmly jammed into the hole in the seat and his stern sticking upright.

Another specimen struck me as a little tall. It was a stone the size of a cocoanut, weighing 34½ ounces, which had been successfully removed from the bladder of an Egyptian by an operation. The description stated that it was the largest on record, and that it could be easily felt bimanually with a finger in the rectum and the opposite hand at the umbilicus. The man lived several weeks after the suprapubic cystotomy by which the stone was removed, and eventually sank from kidney disease.

Time fails me now to tell of aught else I saw in the exhibition, but the result of the polling is already well known. Better luck next time to the Guyite candidate!

Pass List.

First Conjoint Examination, July, 1894.

(Under Old Regulations.)

Elementary Anatomy and Physiology.

Nicholls, F. J.

Chemistry and Chemical Physics.

Payne, J. L. Thorpe, R. S.

Materia Medica and Pharmacy.

Davies, E. C. Lavers, N.
Handson, L. E. C. Rowlands, R. P.

(Under Regulations dated January 1st, 1892.)

Elementary Anatomy.

Bignold, H. H. Hunter, P. D.
Cazenove, W. R. Landon, T. H. W.
Churchill, G. B. F. Parrett, E. E.
Clarke, A. E. Pritchard, R. J.
Crew, E. J. Roberts, J. H.
De Coteau, J. T. Turner, H. S.
Harrison, W. W. Watson, C. F.
Humphry, L. Williams, N.

Elementary Biology.

Barrow, H. P. W. Mules, J. H.
Blythe, T. T. Outred, C. D.
Dowsett, E. B. Perks, A.
Featherstone, F. R. Powell, J. E.
Fowke, W. C. Pritchard, R. J.
Hunter, P. D. Read, A.
Johnson, W. Smith, J. N.
Landon, T. H. W. Ward, P. H.
Lewis, A. C. Williams, N.

Chemistry and Physics.

Baker, W. L.
Barrow, H. P. W.
Churchill, G. B. F.
Croneen, A.
Dyson, J. N.
Hewlett, C. J.
Hope, W. B.
Howells, J.
Humphry, L.
Kirkman, A. H. B.
Landon, T. H. W.
Lewis, A. D.
McGavin, L. H.
McLachlan, A. R.
Outred, C. D.
Powell, J. E.
Pritchard, R. J.
Reid, A.
Richardson, W. S.
Roberts, J. H.
Saward, A. H. M.
Shenton, E. W. H.
Simpson, G. S.
Smith, J. N.
Thomas, A. R.
Thomson, C. B.

Practical Pharmacy.

Alexander, K. B.
Berncastle, H. M.
Dowsett, E. B.
Durbridge, H.
Eason, H. L.
Fowke, W. C.
Goddard, E. G.
Longhurst, E. A.
Marriott, O.
Martin, F. J. H.
Pennington, S. A. B. C. C.

Final Conjoint Examination, July, 1894.

Medicine, Surgery, and Midwifery.

*Steinhaeuser, J. R.

Medicine and Surgery.

*Harding, C. H.
*Wales, H. J. L.

Medicine and Midwifery.

Colley, C. R.
*Evans, R. D.
Hayes, R. H.
Henderson, R.
Peters, E. A.

Surgery and Midwifery.

Brereton, F. S.
*Carpmael, C. E.
Packer, H. D.

Medicine Only

*Beach, H. W.
*Creak, A. B.
*Dukes, E. S.
*Lucas, C. R.
Matthews, A. K.
Tresidder, P. E.
Vallance, H.

Surgery Only.

Armer, A.
Barr, V. H.
Constable, J. C.
Every-Clayton, L. E. V.
Evison, F. A.
Hewetson, H.
*Howes, G. S. O.
*Jiminez, G.
Kearney, C. J.
*Munro, H. A.
Nicholson, T. M.
*Sturges-Jones, W. E.
Wallis, S. S.

Midwifery only.

Burroughs, W. J.
Cock, H. E.
Coleman, J. J.
Collier, H. W.
Hunter, C. H.
Loud, F.
Palmer, A. H.
Pitt, W. C.
Rainbird, A. P.
Reynolds, B. G.
Stoner, H. B.

* Denotes completion of examination.

University of London, July, 1894.

INTERMEDIATE EXAMINATION IN MEDICINE.

EXAMINATION FOR HONOURS.

Physiology and Histology.

First Class.

Collins, V. E., obtained the Gold Medal.

Anatomy.

Second Class.

Levick, G. K.

Materia Medica and Pharmaceutical Chemistry.

Second Class.

Howell, J.

Third Class.

Levick, G. K.

PASS LIST.—ENTIRE EXAMINATION.

First Division.

Goldie, F. W.

Second Division.

Earnshaw, A.
Fisk, E.
Kay, R.
Leader, H.
Roberts, J. T.
Spriggs, E. Ivens.
Whicher, S.

Physiology only.

Second Division.

Ashwin, R. H.
Spicer, A. H.

PRELIMINARY SCIENTIFIC M.B. EXAMINATION.

ENTIRE EXAMINATION.

First Division.

Atkins, J.
Brook, F. W.
Dunston, J. T.
Secretan, W. B.

Second Division.

Fraser, A.
McDougall, J. T. M.
Meachen, G. N.
Munro, D. J.
Stewart, W. G.
Turner, F. D.

Chemistry and Chemical Physics only.

Andrew, E. G.
Moon, A.
Ormond, S. J.
Spearman, R.

Biology only.

Foster, H. B.
Graves, D. S.
Harrison, W. W.
Morgan, T.

Prizes.

Second Year's Students.—Mr. E. Ivens Spriggs; Mr. R. P. Rowlands, equal £17 10s. each.

First Year's Students.—Mr. P. Turner, First Prize, £50; Mr. G. E. Richmond, Second Prize, £25; Mr. H. W. Bruce, Certificate; Mr. W. T. Milton, Certificate.

Reviews.

A Manual of Practical Anatomy. Vol. II. By D. J. Cunningham, M.D., LL.D., F.R.S. (Young J. Pentland, Edin. and Lond., 1894.)

We have perused the second portion of this work with great pleasure, after the masterly writing of the first instalment. In the volume now before us, the Thorax and Head and Neck are treated of, 101 pages being devoted to the former, and 529 to the latter portion of the body. In the opening chapters on the Thorax, we find much that is instructive and well-written, but more detail is to be desired in such parts as the contents of the mediastina, and such terms as the "gullet" and "wind-pipe," savour, to our thinking, more of the butcher's shop than the dissecting-room.

On page 2, in dealing with structures passing through the upper thoracic apertures, all the muscles are omitted, as well as the phrenics and left recurrent laryngeal nerve, not to speak of things of less importance.

Professor Cunningham brings out several new points in his treatment of the intercostal nerves, and includes a most instructive diagram. It will be noticed in this section that only eleven intercostal nerves are described, and that MacAlister's infracostal artery is omitted.

The lungs are throughout most ably dealt with, and the ligamentum latum pulmonis is made much clearer than is usual in text-books.

The description of the heart is good and very detailed, and useful directions are given as to the correct incisions to be made in examining its different cavities, which will enable students to see more in the dissection of one specimen than is often the case.

We consider the pages on the Action of the Heart are out of place in an Anatomy book; but it would have been well if more space had been devoted to the subject of the succeeding paragraph, viz.—Topography. Professor Cunningham has adopted wisely the newer mode of limitation of the aortic arch, which is subjected to no subdivision, but treated as a whole.

We must not leave this section without noticing the many useful diagrams of sections of the thoracic contents and figures of the nerve plexuses and veins.

In the chapter on the Head and Neck, after an ordinary account of the more superficial parts, we find much space devoted to the description of the removal of the brain, which is clearly put and well worth reading. Hints as to the preservation of the brain will be useful to everyone.

The posterior triangle and the muscles of the back next catch our eye, and then we notice the spinal cord, which is dealt with in rather too elementary and superficial a manner, and no topography is included.

Some new diagrams are the only points worthy of mention in the pages devoted to "the Neck," the figure of the external carotid being especially good. Then we come to one of the best sections in the volume, that on the Eye. The extrinsic muscles are clearly described, and a diagram, on p. 373, will help to clear up many of the difficulties which are connected with the sphenoidal fissure. A concise and accurate account of the capsule of Tenon is worth the price of the book to any anatomist, and the chapter also gives good descriptions of the other fasciæ and ligaments of the orbit.

The next subject for commendation is the larynx; but here we find a few discrepancies with the views of other anatomists, in which the author is, in our opinion, in the wrong.

The chapter which we read with the greatest interest was that on the Brain. After all Professor Cunningham has written on the subject, we were somewhat disappointed, as throughout it is evident that the author has been obliged to sacrifice occasionally clearness to the exigencies of space; but, on the whole, students will find the matter far in advance of what is generally included under this heading in Books for Dissection. The various sections on this subject are especially well furnished with figures and diagrams, and the general descriptions will be found quite up to date; it will commend itself exceedingly to men reading for the College.

The concluding chapters on the Ear and Eye are quite on a level with the rest of the book, but the different sections of the temporal bone on the former subject, lose much of their value, owing to their extremely small size; the shortness of the description of the Eye will recommend it to beginners.

Besides the engravings, of which there are some 180, there is a full-page coloured plate, showing the brain exposed in situ, bars only of bone being left: these engravings, which are on the whole good, though most of them are copied from other authors, suffer as mentioned above, chiefly from their want of size. Professor Cunningham deserves, without doubt, to be congratulated on his work, which will be largely studied, especially by readers for the more elementary examinations; those however, who expect to find advanced descriptions and much detail, will be disappointed, as the volumes do not pretend to supply it. All, nevertheless, will find they have not wasted the time spent in its perusal, and they will be sure to gain from it a thorough grounding in the elements of anatomy, which is, and must be, most essential. F.

The Pharmacopœia of the London Hospital. (London: S. F. Hodsoll, Free School Press.)

The revised edition of the London Hospital Pharmacopœia, a copy of which we have just received, fully carries out the main object of a hospital pharmacopœia, namely, that of serving as a guide to the students in the art of prescribing. The work has been brought up to date, and includes those new drugs, the value of which has been proved, and among these the dried and powdered thyroid gland of the sheep finds a place. The appendix contains instructions for case-taking in medical wards, the chemical examination of urine, the preparation of solutions for the preservation and staining of animal substances, and other matters of interest to students.

Guy's Hospital Reports.

The fiftieth volume of the Guy's Hospital Reports has just been published. This is a very important Jubilee, and one of which Guy's men may well be proud. St. Bartholomew's Reports only reach 29 volumes; St. Thomas's Reports, 21 volumes; St. George's Reports, 10 volumes; Westminster Reports, 8 volumes; and the London Hospital Reports, 5 volumes. The Pathological Society's Transactions only contain 44 volumes; those of the Clinical Society, 25 volumes; and those of the Medical Society, 16 volumes. The Royal Medical Chirurgical Society has published 75 volumes, so that the Guy's Hospital Reports, which first appeared in 1836, are easily second among the English Medical Reports and Transactions.

When we remember that important papers have appeared by Addison, Bright, Astley Cooper, Hodgkin, Gull, Fagge, Moxon, and many other famous names, it will be clear that the Guy's Hospital Reports are second in importance to no periodical. The fifty volumes give in reality an excellent history of the progress of English medical science during the past fifty years, and as far as we can make out there is no English medical serial publication better known abroad than these Reports. Only the other day a well known foreign professor of medicine told us that he knew of no more important collection of papers.

The present volume is the largest that has been published, more copies have been printed than of any previous volume, and the list of subscribers is much the longest there has ever been. The vitality of the Guy's Reports is thus as great as ever. Bound up with this volume is an index to the first fifty volumes.

Notices.

Pocket Cocaine Spray.

This little instrument, designed for the application of cocaine solutions to the nasal mucous surfaces, consists of a bent glass tube, having one end drawn out and the other furnished with a rubber teat, so that a solution can be drawn into the tube and then ejected. The spray has been introduced with a view to obviate the toxic effects which may result from the too free use of cocaine solutions. The patient is enabled by means of this instrument, to control the quantity since the dose cannot be exceeded, the solution being prepared from tabloids, one or more as ordered. The price of the spray is 2s. 6d. Messrs. Burroughs, Wellcome & Co., Snow Hill Buildings, E.C., are the manufacturers.

Emal Keteet.

Emal Keteet is the name given to a natural product possessing emollient and absorbent properties, and used as a dusting powder. Attention was drawn to this substance by Dr. Allan Jamieson, of Edinburgh, who, in a paper read before the Dermatological Section of the British Medical Association, at Newcastle-on-Tyne, 1893, described its effects in softening horny accretions encountered in some states of keratosis of the palms and soles. It appears, also, that used as a dusting powder, it possesses antipruritic properties. The sample has been sent by Messrs. Burroughs, Wellcome & Co., Snow Hill Buildings, E.C.

A Poem.

(WITH APOLOGIES.)

(Suggested by the state of the Colonnade and landings on Monday, 9 a.m.)

Sing a song of sepsis, a landing all awry,
Linen for the laundress on Monday greets the eye;
When the ward is opened the germs begin their game,
Isn't such a tainted air unworthy of our fame?
The surgeon, at a private Op., raking in his money;
The dresser, in the smoking-room, consuming "Sun-dried Honey;"
The nurse was in the kitchen, the ward-clerk never came
The streptococci did their worst;
The dresser got the blame.

L. O.

Appointments.

Grove, W. R., M.D. St. And., M.R.C.S., has been re-appointed Medical Officer of Health for the St. Ives Urban Sanitary District.

Hodgson, V. J., L.R.C.P. Lond., M.R.C.S., D.P.H. Camb., has been re-appointed Assistant Medical Officer of Health for the Port of London.

Knaggs, R. Lawford, M.A., M.D., M.C. Cantab., F.R.C.S., has been appointed an Honorary Assistant Surgeon to the General Infirmary, Leeds.

Knight, John Tomlinson, M.R.C.S. Eng., has been re-appointed Medical Officer of Health to the Carlton Local Board.

Morice, Chas. G. F., L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Resident Surgeon to the Grey River Hospital, at Greymouth, New Zealand.

Poland, John, F.R.C.S., has been appointed Consulting Surgeon to the St. Pancras and Northern Dispensary, *vice* Henry Smith, F.R.C.S., deceased.

Puddicombe, W. N., M.R.C.S. Eng., has been appointed Honorary Medical Officer to the St. Albans Hospital, *vice* Geo. Mowat, M.R.C.P. Edin., M.R.C.S. Eng., resigned.

Stoker, F. O., L.D.S., R.C.S.I., 19, Clare Street, Dublin, has been appointed Surgeon-Dentist to the Staff of the Bank of Ireland.

Taylor, Arthur S., B.A., M.D., B.C. Cantab., F.R.C.S. Eng., has been appointed Honorary Medical Officer to the Surbiton Cottage Hospital.

Sport.

Cricket.

THE season of 1894 ended rather more satisfactorily than was at one time anticipated, the final result reading:—Matches played, 15; won, 7; lost, 4; drawn, 4. Five matches were scratched, three by ourselves! and one not played owing to rain. The team was never the same in two successive matches, and the only time we played a really full team was in the final Cup Tie. What was the cause of this is not known; work no doubt prevented some from assisting, but others were undeniably slack, and could easily have played if they had wanted to. Perhaps the large proportion of "out" matches had a good deal to do with it; now that our ground is being got into such excellent order, there should be no difficulty in arranging more "home" matches.

The matches won were Ealing, Streatham, Crystal Palace, "Old Guyites," and our three cup ties v. Charing Cross, Middlesex and St. Thomas's Hospitals. We suffered defeat from Beckenham, where we had a very poor team indeed; from Mitcham, at Mitcham; from Surrey Club and Ground, where again our team was nothing like so good as it ought to have been for an important match; and from Dunstable Grammar School, thanks in great measure to a deluge of rain just after our innings was finished. Drawn matches were played with Crystal Palace, whom we got out for 138 just before the rain came and stopped play; with Repton School; with Mitcham, on our ground, and with Felstead School.

We won the Inter-Hospital Challenge Cup again with some ease, this being the fifth year in succession. The only exciting match of the three was with Middlesex in the semi-final, but thanks to Alexander and Ham, whose batting on a bad wicket was most plucky, the excitement did not last long. We met Charing Cross in the second round at Honor Oak Park—having drawn a bye in the first—and beat them by ten wickets, the scores being—Guy's, 125 and 4 for no wicket; Charing Cross, 62 and 63. Middlesex were our opponents in the semi-final, which was played at Forest Hill, and the scores were—Guy's, 172; Middlesex, 124 and 89 for six wickets. In the final tie we played St. Thomas's, and beat them very easily by ten wickets. The match was played at Honor Oak, and the scores were—Guy's, 225 and 19 for no wicket; St. Thomas's, 125 and 115. Joyce signalised his last appearance in cup ties by a splendid performance, scoring exactly 100 not out, and securing ten wickets in the two innings at a cost of 80 runs.

Turning now to individuals. Joyce only played for us in three matches, but scored 165 runs for three completed innings, giving him an average of 55, and took sixteen wickets for 167 runs, average 10·43 per wicket. W. I. Hancock's batting was most consistent throughout; he only failed to get double figures once, and then was not out, the runs required having been obtained; he has the excellent average of 41·22 for nine completed innings; his bowling was also most serviceable. Francis was out of form for a great part of the season, but still comes out with a very fair average. Shorland was most successful with the ball, having secured forty-nine wickets at an average cost of just over 10 runs; his hitting was as clean as ever when he got into form. Perks batted excellently at times and his fielding was brilliant as a rule. Nicholls began well with 43 at Beckenham, but fell off considerably, his bowling analysis suffered severely from the absence of the regular bowlers in the earlier matches. Alexander proved a most efficient substitute for Loud behind the wickets, and his plucky batting at times, when runs were badly wanted, was of the greatest service to his side. Trouncer played very seldom, but did one or two good bowling performances. Ham was useful in batting when he played, but his bowling was by no means deadly this year. Several other gentlemen assisted us at various times, and their services were much appreciated. Our fielding was, as a rule, very safe all round, and it would be difficult to single out any individual as superior to the rest. Unfortunately for next season's prospects, seven, if not eight, of this year's team, will not be available for cup ties, these including our three regular bowlers and the four most reliable bats—a bad look out certainly. We must hope for good new blood, and some increase in keenness among the old.

BATTING AVERAGES.

	No. of Innings.	Total Runs.	Most in Innings.	Times not out.	Average.
J. H. Joyce	4	165	100*	1	55
W. I. Hancock	11	371	110	2	41·22
A. Perks	12	286	86	–	23·83
E. T. Shorland	12	214	49	2	21·40
C. J. Francis	15	305	44	–	20·33
F. J. Nicholls	15	236	43	2	18·15
C. A. Trouncer	6	100	47	–	16·66
N. H. Pike	14	172	40	2	14·33
P. C. Prince	8	99	32*	1	14·14
K. B. Alexander	12	122	39	2	12·20
R. B. Stamford	7	63	30	–	9

Also batted—B. B. Ham 21, 3, 21; A. H. Grace 21, 5, 13; R. T. Fitzhugh 6, 4, 14; H. Simson 9, 3, 7*; N. C. Cooper 21, 13; H. C. Sharp 6, 17; F. C. Wetherell 10*, 5; F. Loud 1; E. Reid 2.

* Signifies not out.

BOWLING AVERAGES.

	Runs.	Wickets.	Averages.
E. T. Shorland ...	508	49	10·03
J. H. Joyce ...	167	16	10·43
N. H. Pike ...	124	10	12·40
C. A. Trouncer ...	141	10	14·10
W. I. Hancock ...	400	28	14·28
F. J. Nicholls ...	367	16	22·17

Also bowled—B. B. Ham, 102–2–51; E. Reid, 130–7–18·57; F. C. Wetherell, 82–1–82; H. C. Sharp, 39–4–9·5; A. Perks, 7–1–7.

ATHLETIC NOTES.

The United Hospitals' Athletic Club meeting, as many expected, simply resolved itself into a tooth and nail struggle between Bart.'s and ourselves, and our team,

though beaten in failing to obtain the odd event, came out of the contest in no way disgraced.

Six to five was the by no means substantial, but yet sufficient margin, and in many of the races of which Bart.'s furnished the winners, our representative *proxime accessit*—to wit, the hurdles, high jump, and 220; and it may be of slight consolation to us to consider that one of those every-day mishaps, which so often occur in sports, might have turned the tables in our favour and sent us home rejoicing; this, as many of our readers are aware, is the first time the Shield has been won by the odd event.

All our victories, except the hammer, were of the "hollow" variety, and no one was able, in the slightest degree, to extend Munro in the long distance races.

By-the-bye, we find on perusing our programme that this very excellent runner has done an unique performance in Hospital annals, in having won the same two races for four consecutive years, and, no less a distinction, in each he has established a new record, that of the three miles being again lowered by him last Saturday.

Our sprinter and jumper, Bell, has also accomplished a record, having occupied the leading position in nine events during his four years, and this he has accomplished at three meetings, although he failed to win a first prize at the '91 meeting. Following him closely, with eight events each, are F. R. Cross, of King's, and B. C. Green, of Bart.'s, the latter of whom won four events each year he competed.

Of the five records made, as our table shows, by Guy's men, R. R. Conolly holds that for the 100; H. T. S. Bell the 220 and high jump, and Munro that for the two long races.

The five-mile bicycle race seemed to have been introduced as a gift to the Guy's Hospital Bicycle Club, which furnished both first and second places in Austin Woods and Millbank Smith respectively.

TABLE SHOWING POSITION OF HOSPITALS.

	Bart's	Guy's	Thomas's	King's	George's	University	Mary's	London	Middlesex	Westminster	Charing Cross
100 yards	5	R4	5	7	2	2	—	1	2	—	—
220 yards	4	R4	3	9	3	2	—	1	2	—	—
¼-mile ...	10	4	—	R10	1	2	1	—	—	—	—
½-mile ...	R13	2	—	5	3	2	3	—	—	—	—
1 mile ...	4	R5	—	4	6	7	1	1	—	—	—
3 miles ...	4	R5	2	1	8	3	4	1	—	—	—
Hurdles ...	R7	8	5	1	5	1	1	—	—	—	—
High jump	9	R10	5	—	1	—	2	—	—	1	—
Long jump	R8	8	5	2	1	1	—	2	—	—	—
Hammer ...	R7	6	10	—	4	—	1	—	—	—	—
Shot ...	R6	9	4	—	1	1	4	3	—	—	—
Total	77	65	39	39	35	21	17	9	4	1	0
No. of times Champion Hospital:—	9	7	5	3	3	1	—	—	—	—	—
No. of Records:—	5	5	—	1	—	—	—	—	—	—	—

R Denotes record.

Guy's Hospital Rifle Association.

GUY'S v. HARROW.

ON 26th ultimo, the Hospital representatives journeyed to Harrow and met the School team. The day was perfect for shooting, and probably accounted for the phenomenal shooting of the boys, for they ran up a total of 473, a record never before made by any Public School. Against such shooting Guy's had no chance, but thanks chiefly to Luce and Telling they compiled the very creditable score of 392, notable also as being our record for two ranges. Scores:—

	200	500	Aggregate.
GUY'S.			
Scott-Turner	19	21	40
Robinson	21	25	46
Ashwin	24	22	46
Telling	27	30	57
Secretan	26	26	52
Jenkins	22	21	42
Fulham-Turner	22	27	49
Luce	30	30	60
			392
HARROW.			
Rose	26	27	53
Martin	31	28	59
Smith	32	30	62
Rowlatt	26	26	52
Harrison	30	33	63
Bushell	27	30	57
Karslake	34	31	65
Hobson	31	31	62
			473

GUY'S v. ROYAL COLLEGE OF SCIENCE.

On the 9th instant we shot a return match with Charing Cross, and simultaneously one with the Royal College of Science. The latter were two men short, occasioning the counting of our four best scores only. Shooting on the whole was good, especially Telling's excellent 87. Lloyd of Charing Cross did well with 84. At 600 yards the score went strongly in our favour, and eventually we had the pleasure of beating both teams.

	200	500	600	Aggregate.
GUY'S.				
Scott-Turner ...	22	16	21	59
Secretan ...	26	26	21	73
Telling ...	30	27	30	87
Fulham-Turner ..	25	26	31	82
				301
ROYAL COLLEGE OF SCIENCE.				
Parkinson ...	30	25	19	74
Porterfield ...	22	24	19	65
Merrett ..	25	18	20	63
Strange ...	29	23	23	75
				277

GUY'S v. CHARING CROSS.

	200	500	600	Aggregate.
GUY'S.				
Robinson ...	24	13	11	48
Scott-Turner ...	22	16	21	59
Michael ...	17	20	19	56
Secretan ...	26	26	21	73
Telling ...	30	27	30	87
Fulham-Turner ...	25	26	31	82
				405

	CHARING CROSS.				
Lloyd	...	26	30	28	84
Clarke	...	24	24	16	64
Walker	...	19	28	15	62
Staten	...	22	14	23	59
Street	...	29	21	9	59
Spencer	...	18	19	16	53
					381

UNITED HOSPITALS CUP, BISLEY.

The language! The recording angel had a brisk time on the 12th inst. The team disported themselves at the "Jeffery" in the early part of the afternoon, and distinguished themselves by scores of from 8 to 22. This looked healthy! The anemometer showed a gentle breeze of twenty miles an hour; occasionally, to vary the monotony, wandering up to 28. This meant about six feet of wind and allowance for gusts. Then, to further worry us, the sun indulged in occasional peeps sufficient to upset all ideas of elevation. Such were the conditions, and the result was utter downfall to nearly everyone. When such old hands as Child and Robson, of St. Thomas's, came to grief, there was some excuse for others. In spite of this, Charing Cross shot up wonderfully well, and at one time were nearly certain of winning, but the last pair fell off, and St. Thomas's again won the Cup, this time, however, by a bare 6 points—not much on a team shoot. As regards our men, Jenkins was taken ill on the range, and this probably accounted for his score. Telling, in whom our hopes lay, came woefully to grief, and finished with 28. Some excuse may be found in the fact that we had no mats, and steadiness was hard to get on a slippery piece of cocoanut-matting. St. George's were one man short, but as he would have had to make 55 to beat us, —rather a large order that day—we were spared the disgrace of being last. In spite of this, St. George's won the prize for top score, Henery of the Artists making 57. Score:—

GUY'S.	
Secretan...	46
Michael	33
Ashwin	47
Jenkins	31
Telling	28
Fulham-Turner	47
	232

	RESULT.	
1.	St. Thomas's	286
2.	Charing Cross	280
3.	St. Mary's	271
4.	Guy's	232
5.	St. George's	178

PRIZE COMPETITION.

This was shot at Ilford on the 16th instant. The attendance was less than last year, owing to the fact that several of our "regulars" were away at examinations. The weather was threatening, the rain, as usual, starting as soon as we commenced firing at 200 yards. Here the shooting, with the exception of a 28 from Sells, was decidedly below the mark. At the next range, the rain fell in downright earnest, and being coupled with an uncomfortable wind, made accurate shooting very difficult. In spite of these adverse circumstances, Sells compiled another 28, while Fulham-Turner and Telling each put on the respectable score of 33, a record for the Guy's Hospital Rifle Association. Telling's shoot was especially good, six bulls following an outer for sighting shot. The seventh round was, by a mistake, delayed, and the elevation lost, otherwise a "possible" or at least 34, would unquestionably have been made. On going back to 600 yards, these three men were equal, but the longer range soon produced differences. Fulham-Turner went to pieces with 21, and Sells was worse with 15. Telling, however, kept well on the target, and finished with 27, making a total of 83, a very creditable performance for such a wet and trying afternoon. Scores:—

	200	500	600	Hp.	Aggregate
Telling	23	33	27	—	83
Fulham-Turner ...	23	33	21	—	77
Sells	28	28	15	—	71
Ashwin	25	16	20	5	66
Scott-Turner ...	23	13	17	10	63

Births.

BERRY.—On August 3rd, at Grantham, the wife of H. Poole Berry, M.B., of a daughter.

MUSPRATT.—On July 12th, at Tantallon, Madeira-road, Bournemouth, the wife of Charles D. Muspratt, M.D., of a son (stillborn).

ROBERTS.—On July 24th, at Halstead, Essex, the wife of C. Gordon Roberts, M.A., M.B. Cantab., of a daughter.

Marriages.

MOTHERSOLE—RALFE.—On July 12th, at St. John's, Birkenhead, by the Rev. Gerald C. Dicker, Vicar, Robert Devereux Mothersole, M.D., M.S., F.R.C.S., of Bolton, son of the late Thomas Mothersole, of Colchester, to Susanna Mary, eldest daughter of the late F. Whitfield Ralfe, of Lancaiach, Glamorganshire.

WADDY—WHITCOMBE.—On July 24th, at Llanaber (Barmouth) Parish Church, Henry Edward Waddy, L.R.C.P. Lond., M.R.C.S., of Gloucester, to Ethelinda Helen, youngest daughter of George Whitcombe, of Tuffley Knoll, Gloucester.

Deaths.

RAKE.—On the 10th inst., at The Old House, Fordingbridge, Salisbury, Thomas Beavan Rake, M.R.C.S. Eng., and L.S.A., aged 68 years.

SMART.—On July 14th, at Scarborough, suddenly, John Cass Smart, M.D., of Coombe Hay Manor, Bath, in the 79th year of his age.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of he Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

SEPTEMBER 8, 1894.

An Educational Plea.

THERE lies before us the invitation card to the first meeting of the Physical Society for the forthcoming Session, at which it is announced Mr. Lockhart Stephens will read a paper on "Medical Education in relation to General Practice." Without wishing to anticipate Mr. Lockhart Stephens in any way, the title of his address suggests to our minds the cognate subject of the General Education of the Medical Man. Opportunity is the measure of duty, and the opportunity of the doctor for becoming a public benefactor and leader is, in this age, possibly, second to none. It will, however, we think, be generally admitted that if he is to rise to the full height of his opportunity, the medical man requires other qualifications than the Conjoint Diploma or even those higher distinctions earned at the universities. The distinguished personages who from time to time come down to encourage and inspire the members of our Medical School scarcely ever fail to impress upon them that the medical man must above all things possess character. Well, that is a term of very wide meaning, and certainly embraces a great deal to which no reference is made in the curriculum advertised in "blue book" or "green prospectus." Over and above general morality of speech and action, we take it to include some knowledge of business and business-like method; an acquaintance, more or less profound, with the political and social problems of the day; a sympathetic insight into the conditions under which people earn their living and spend their lives; the possession of a pure public spirit; of a cultured mind, the capability of seeing what should be done or said, and the capacity of doing or saying it effectually and with dignity.

How far this ideal is from being realised in practice is painfully apparent every day; yet what else can we expect. *Ex nihilo nihil fit.* In order that a man may possess a sufficient minimum of knowledge of medicine and surgery, he is subjected to a five years' course of instruction and examination, but the other side of his nature, although admittedly of vital importance to the success of the first, is left to take care of itself; we can only say that this is not a scientific method, and that it stands condemned in the results, which are too obvious to call for detailed comment.

Our purpose in uttering this criticism is to give point to a suggestion, which, if carried out, might remedy in some measure this deficiency in the training of the general practitioner. We should like to see an institution, similar in some respects to the Unions of Oxford and Cambridge, set up within these walls. Men go to those universities, it is true, first to acquire certain branches of learning, just as students come here with the special purpose of obtaining scientific knowledge; but, admitting this, there are plenty of instances to prove that the debates of the Unions, no less than the lectures of the Schools, are a formative influence in producing characters which, as leaders of thought and action, help to mould the destiny of the people.

The Physical Society of this Medical School, to quote from its first rule, "exists for the cultivation and promotion of Medicine, Surgery, and allied subjects, and for the discussion of matters of interest in relation to medical education." The first rule of the Society we suggest, would be in similar form, and apply to everything which goes to make up the general education of the medical man, and which does not come within the scope of the Physical Society. An instrument for the carrying out of this idea is at hand in the shape of the Debating Society, which is now a constituent institution of the Clubs' Union; and we appeal to the authorities of that Society to give consideration to the project, and during the coming session invoke the aid of some of our more honoured and distinguished public men, which we feel certain would be cheerfully given, by presence and voice, in the College Smoking-room. It would, indeed, be gratifying to find Guy's adding to its laurels by sending out not only the best trained doctors but the most enlightened men, and thus inaugurating a movement which would spread and shed fresh lustre on the profession at large.

A Case of Median Cervical Fistula.

CLINICAL LECTURE BY MR. DURHAM.

I WISH to-day, Gentlemen, to tell you about an exceedingly interesting case we have now in the hospital; and to give you my reasons for the diagnosis which I have formed concerning it: after which I shall proceed to operate.

You know that in the process of development of the fœtus various organs and structures, ducts and canals appear, fulfil their purpose, and then proceed to waste and disappear,—by a process of absorption in the case of the solid parts, by a process of closure and obliteration in the case of the ducts and canals. Sometimes, however, it happens that one or other of these fœtal structures, organs, canals or ducts, persists through life, and is not merely represented by the little fibrous tissue that ought to remain, and does remain in almost all cases, but the organ, structure, duct or canal itself persists. Of course, it is somewhat changed from the condition in which it exercised its function during fœtal life; but still it persists. When this takes place such remains of fœtal structures are always liable to be troublesome, and may sometimes become dangerous. The degree of trouble they give rise to, and the danger they involve, will, of course, vary very much in accordance with the particular case, and the particular structure concerned. If my diagnosis is correct, it is with respect to a persistent fœtal structure that the condition with which we have to deal to-day has arisen.

In connection with the history of the case which I will now relate, very little need be said. As stated in the report, it is as follows:—

The patient is a man, æt. 20. When four years of age he had scarlet fever, immediately after which it was noticed that he had a small swelling situated immediately over the trachea, about three-quarters of an inch above the upper margin of the sternum. Two years subsequently, this was lanced. (Apparently, it had got larger and more troublesome, in consequence of which it was lanced.) Almost continuously since that time there has been a discharge from it. This discharge has, however, caused the patient comparatively little inconvenience except when, as occasionally happened, the discharge ceased. (What is meant here is that the opening from which the discharge came got blocked up, or healed over; the discharge accumulated in the space behind, thus giving rise to pain and discomfort.) The patient is a healthy-looking man, and the swelling appears to be his only trouble. It is described as being rounded in outline, about an inch and a half in diameter, and projecting about half-an-inch from the surface. It fluctuates. Its margins are thick and somewhat hardened. The surface of the skin over it is reddened. The summit of it is of a rather dusky hue; the skin dry and scaly. It is tender on pressure, and moves freely on the underlying structures. (On this latter point I would not be too sure. It is put down in the report in this way; but do not take that statement as from me.) It moves upwards when the patient swallows. From its upper margin there runs a hard cord-like structure which is attached above to the lower margin of the hyoid bone. Around especially the upper part of the swelling there is considerable induration of an irregular character.

That is the description of the case recorded the day before yesterday when the man came in. Yesterday the swelling opened, and some discharge took place. Microscopical examination showed that the discharge consisted of pus corpuscles and a few red corpuscles. It was a curdy kind of pus that was discharged.

Here is the man, and you can see the swelling in the middle line. From the resistance it offers to my fingers as I grasp it between them, you will see a hard mass which I can trace distinctly up to the hyoid bone in front of the thyroid cartilage over which it is moveable. Down below it does not seem to be quite so moveable; that may be from adhesion to the trachea, due to an inflammatory process. The swelling, you will see, has burst and discharged.

What is it, then, we have here to deal with? At first sight, unless you made a careful examination, you might be inclined to suppose it an abscess in the front of the neck, or else a sebaceous cyst. It might be so. But in connection with this you have to notice, first, that the

thing has been in existence ever since, or even before, the patient's birth; secondly, that the condition did not show itself from the very first, but only after an attack of scarlet fever, when, according to the man's statement, it appeared as a rounded swelling; and in the next place, although that rounded swelling was punctured, and some matter evacuated so that he was, for the time being, relieved from the pain and inconvenience he suffered, it has never healed properly, but has remained open. The opening may have closed over a little, a scab may have formed, or even the edges of the wound may have united, but as soon as that happened the matter, or the exudation—call it what you will—has gone on forming and distending the sac which has again opened. Thus the thing has persisted, and in all probability will go on as long as the man lives, unless some measures are taken for getting rid of it.

Observe one point, a point which is very essential in making the diagnosis absolute, but one which we could not insist upon, or, at any rate, which I did not choose to insist upon. When I attempted to pass a probe the patient demurred on account of the pain it caused; but supposing I had persisted in the attempt it would probably have gone up in front of the structures of the neck as far, or nearly as far, as the hyoid bone; it would, in fact, have gone up in the middle of that hard cord, extending to the hyoid bone. Consequently, my impression about the case is that it is one of those cases which some call median cervical fistula, or persistent thyroid duct. In the early stage of development there is a duct called the thyro-glossal duct, extending from what would be the upper part of the thyroid gland to the back of the tongue, where it ends in the foramen cæcum. In the early stage this canal or duct is open. It is in association with this that the isthmus of the thyroid body is said to be developed; and certainly it would appear to be in association with this, or with some persistence of this, that that extension upwards of the isthmus of the thyroid body that is sometimes found occurs—the pyramidal extension of the thyroid body; and it is probably in connection with this that those accessory thyroids are formed which sometimes are found in the middle line extending up from the thyroid.

Here I might just mention one of those strange coincidences which sometimes happen in the course of our practice and experience. It was only yesterday afternoon that Mr. Howse was operating upon a case of thyroid disease for the removal or section of the median lobe or isthmus of the thyroid; and in that case there were these accessory thyroids and this pyramidal extension also, running straight up from the isthmus of the thyroid; in point of fact, illustrating one of those conditions associated with this thyroid duct of which I am speaking. In Mr. Howse's case the portion of the thyroid duct associated with the development of this part of the thyroid was very persistent; in my case it is the other portion of the bifurcation of the thyroid duct that has persisted—at least, so I judge—and which has given rise to the trouble we have here. It is a curious coincidence.

This thyroid duct, as a general rule, having fulfilled its function, passes away and disappears entirely as other ducts and canals of fœtal life do. But, as I say, sometimes it persists. When it does so, I believe it remains in a quiescent state for a certain period of time—we cannot say how long; but after a time, from some stimulating or exciting cause secreting action is set going. It may be that the scarlet fever in this case had something to do with it. In one or two other cases of cervical fistula I have known an attack of scarlet fever render, or seem to render, that which before had seemed to be of very little trouble, a source of such trouble as to necessitate something being done. The exudation into the closed duct causes a swelling to appear, which may be the first thing to direct attention to the condition. Then the part inflames, and in this case it was opened. This is what generally happens in these cases. The inflamed and distended persistent duct does not generally open externally at first as some other cervical fistulæ do; for example, those associated with the branchial clefts, which are generally open from the first. As a rule, these central median cervical fistulæ associated with the thyroid duct are not open from the first, but only become so one, two, three, or four years after birth, or even later.

Once having happened, the thing goes on. Secretion begins, the sac distends and eventually bursts, there may then occur temporary closure, but secretion again commences, followed by distension; and again there is discharge. But all the while this is going on in the interior of the duct, some inflammatory action occurs above and around it; and this is an important fact to remember, because such an inflammatory process, by causing thickening and hardening around it, makes it more adherent and closely connected with the surrounding structures, and more difficult to separate from them. It is just possible from the feeling this has that there may be some new growth properly so-called present; but I am inclined to think that the induration and hardness we feel are merely of inflammatory origin.

Here let me remark that those remains of fœtal life are very apt to behave badly,—or, if not to behave badly themselves, to form the nests in which something of bad behaviour or malignant character is very prone to form; this being so it is very desirable in all cases where it is practicable to get rid entirely of those things that may prove a nuisance, or the seats of serious evil.

What is to be done in these cases? One might freely open and scrape out the sac which is found in front of the lower part of the neck, but, that being done, though matters might be in a better condition for a time, very speedily, indeed, the same old story would be repeated, and we should have the same trouble as before. Only

one thing, so far as I know, is effectual in these cases, namely, to dissect out and remove entirely all the abnormal structure. Such a process is not by any means always easy, and it is rendered more difficult by the inflammatory adhesions and thickening outside and around the part that has to be removed. It is not a thing to be turned out with the nail: we shall be obliged to dissect it out; and seeing the structures on which, and amid which, it lies, such a process will have to be conducted very carefully indeed. However, I do not despair of being able to accomplish this. I propose, by dissecting out, to remove all the abnormal structure we find, even though, as I have no doubt will be the case, on opening the sac freely, clearing out the contents and passing a probe upwards, we find it go nearly, if not quite, to the hyoid bone. However that may be, we shall trace it up as far as we can and dissect the part out.

What are our prospects of success? If we succeed in getting the thing entirely out right up to where the tube is obliterated we shall succeed in curing the patient no doubt; but if ever so small a portion of the lining membrane of the duct is left the probability is that it will become the starting point of further trouble. In these cases you must do it "all in all, or not at all." To be successful you must get the whole out, for it will be of comparatively little use to get only a part out.

Any other method of treatment in these cases is probably futile. Over and over again injections have been made, cauterisations and other means have been tried; but always the trouble has been recurrent unless the whole thing has been completely removed; and that this is possible experience has shown. I myself have removed two or three. I have here a specimen which was taken from a little girl of six. In front of the neck, a little below the hyoid bone was a fistulous opening with a good deal of induration round it. A cord-like swelling extended up to the hyoid bone. It had been first noticed two years before, that is, when the patient was four years old, as a roundish swelling. This had been opened and some cyst wall had been cut away; but the swelling had recurred, and some discharge kept coming away. In these circumstances I was called in to see her. It was clear that the only thing to do was to dissect out thoroughly, however far it might extend, the sinus or fistulous tract. I had some little difficulty in doing this. I dissected out right up behind the hyoid bone.

One point I am afraid I have omitted. The thyro-glossal duct, as I told you, passes from the upper part of the situation of the thyroid body to the foramen cæcum, which opens on the dorsum of the tongue posteriorly. When the hyoid bone is developing the thyro-glossal duct seems to be stopped, closing behind the hyoid bone, and becoming adherent or closely associated with the body of that structure. The portion above the hyoid bone leading up to the foramen cæcum then becomes obliterated. (Sometimes, by the way, cysts are formed in that,—dermoid cysts.) The other part closes also, and, under normal circumstances, becomes obliterated; but if the thing persists the duct remains open, and extends as far down as before. You will thus see how it is, if it only extends normally as low as the isthmus of the thyroid body, that we find it sometimes as low as a point just above the sternum. You will readily understand that. The discharge which accumulates cannot escape through the skin at first, there being no opening. Extending in the direction of least resistance, in accordance with gravitation it finds its way downwards; and the more the sac is distended, the more is there extension downwards; and, when inflammatory adhesions form round it, it is pulled still further downwards; so that it gradually extends beyond the point at which it might originally have opened.

In the case of this child the fistula had not extended far down at the time. We dissected it all out, and sewed the parts together, after which the place healed up entirely. On examining the specimen we found that a bristle could be passed through the top; so I made a little further incision, and touched the upper end of the wound with the point of a cautery. Although this was done four years ago there has been no recurrence of the trouble.

Some years before that a little girl living in Long Lane, ten years old, had been in hospital supposed to have had a dermoid cyst which was opened. It did not turn out very well; a fistulous opening having remained. When I saw her I came to the conclusion that nothing but complete extirpation of the cyst would lead to cure. I extirpated the cyst entirely but with very considerable difficulty. It went up not only to, but beyond the hyoid bone to the extent, I suppose, of about a quarter of an inch. I got the whole thing out, however, and the child got perfectly well.

We shall operate on the man you have seen, and try to effect a similar cure. We shall probably have some difficulty in getting the part nicely covered up; but I think we shall succeed. If we do not, however, we shall, at least, be quite free to confess our failure.

I wish, however, to call your attention to another class of fistulæ in the neck. The peculiar character of the fistulæ we have spoken of is that they are in the middle line. But we have fistulæ in the neck also which are connected with the unclosed branchial clefts or fissures. These, however, are lateral, not median. Sometimes they are bilateral, one being present on each side. They are very troublesome things to have to do with. Some patients do not mind them very much, but others care a great deal, and would give anything to get the thing cured. A young lady with a little weeping spot on the side of her neck deems herself in a very unenviable position. In the case of a young man it matters less; but even he may feel it very disagreeable, particularly when the track may have got inflamed.

I have here a specimen, taken from the neck of a doctor's son, who had suffered from such condition all his life, having been born with it. A little weeping had always come from it. After an attack of scarlet fever it had got very much inflamed, and there was a good deal

of sloughing of the skin. On going to see him I passed a probe in at the opening, which was situated about three-quarters of an inch above the sterno-clavicular notch, and found that it travelled along the track as far as the cornu of the hyoid bone. I had no doubt at all as to the character of the fistula. We slit up the sinuses that had formed about it from the inflammatory action till we got on to the track of the fistula itself. When I got to the cornu of the hyoid bone I imagined I had got to the end of the matter, but was astonished to find the probe travel still further, and we had to follow with our dissection till the base of the styloid process was reached. To this it seemed to be attached, or in close connection with it. I cut it off there, and closed the wound up. The skin having been duly slit up over all the other sinuses resulting from diffused inflammation about the lower part of the neck, they afterwards healed perfectly well, and, although the operation was performed three years ago, there has not been a drop of discharge since. For complete success this is the procedure that is necessary. The operation may be difficult; it may even be dangerous; but it will not be dangerous if you know what you are about; while if you go recklessly about it you may easily get into trouble.

What are the morals I wish to impress upon you? First, I want you to bear in mind the existence of these congenital or developmental persistent ducts, and the cysts and troublesome fistulæ to which they give rise. You have to recollect that there are those in the middle line associated with the thyro-glossal duct, and the lateral ones associated with unclosed branchial clefts or fissures. Recollect, too, that though these cases are rare, yet they do occur, and they may prove sources of great disappointment to you. A child is brought to you about four years old, with a small rounded swelling in the neck, which is thought to be very ugly. You say to the mother in the most cheerful way, "That is very easily got rid of. No doubt it is a sebaceous cyst or something of that kind." Or perhaps, if the skin is reddened over it, you say, "It is only an abscess that wants opening." You push your lancet in, and perhaps scrape out some of the contents and expect it to heal up nicely. The part contracts, and for a time all looks hopeful; but the place does not heal. The mother comes again, complaining of a constant discharge from the child's neck, and asking if nothing can be done to stop it. You perhaps inject it with Tincture of Iodine, or Carbolic Acid, and say it will be all right. But it does not come all right. The thing goes on; and the case involves a considerable amount of annoyance to you as well as to the parents. On the other hand, do not undertake the removal of these things with over-confidence. They often involve procedure of extreme difficulty; and the success of your treatment will bring you the more credit after having yourself acknowledged so much.

Just because these cases are rare it is important that you should be reminded of them. It is just your pronouncing correctly upon the exceptional case that you find occurring every now and then in your practice that will gain you the highest credit. Everyday cases are just everyday cases; but sometimes you will get a case that is not an everyday case; and it is well to be prepared for such.

Further particulars of the subsequent history of the case on which this Lecture was founded will be published hereafter.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Nervous System.

Philip	7.	Cerebral.
	15.	Locomotor ataxy. Fractured femurs.
	20.	Chorea. Mitral stenosis and regurgitation.
	22.	Peripheral neuritis.
	23.	Delirium. ? Cause.
	24.	Ptosis. Oculomotor paralysis, third and fourth left nerves.
	26.	Pseudo-hypertrophic muscular paralysis.
	29.	Epilepsy.
	31.	Locomotor ataxy.
	30.	Paresis of legs. Wasting.
	35.	Cerebral tumour.
Stephen	1.	Progressive muscular atrophy.
	3.	Diphtheritic paralysis. Recovery after injections of antitoxin.
	12.	Cerebral tumour
	17.	Paraplegia. Myelitis.
	20.	Hemiplegia. Syphilis.
	22.	Partial double facial paralysis.
	23.	Exophthalmic goître.
	30.	Paralysis agitans.
	33.	Progressive muscular atrophy. Aortic stenosis and regurgitation.
	36.	Cerebral syphilis.
Mary	8, 23, 47.	Chorea.
	13.	Right hemiplegia.
	36.	? Cerebral tumour.
	42.	Diffuse myelitis.
	50.	Peripheral neuritis.

Circulatory System.

Philip	34.	Mitral stenosis and regurgitation.
	39.	Mitral stenosis and aortic regurgitation.
Stephen	2.	Ulcerative endocarditis.
	5.	Aortic stenosis and mitral regurgitation.
	8.	Mitral regurgitation.
	9.	Aortic and mitral regurgitation and mitral stenosis.
	21.	Angina pectoris.
Mary	10.	Mitral stenosis and regurgitation. Aortic regurgitation.
	11, 14, 16, 17.	Mitral regurgitation.

MARY 18. Mitral stenosis and regurgitation.
24. ? Innominate aneurysm.
25. Mitral stenosis and regurgitation.
31. Aortic stenosis and regurgitation. Mitral regurgitation.
Cot 55. Congenital heart disease.
40. Chlorosis.
49. Tricuspid regurgitation.

Abdomen.—Alimentary System.

PHILIP 1. Vomiting. ? Cause.
13. Enlarged liver. ? Malignant.
14. Dysentery.
17. Pyloric carcinoma. Enlarged liver.
18. Gastric ulcer.
STEPHEN 6. Abdominal pain. ? Perityphlitis.
10. Enlarged liver. Cirrhosis. Jaundice.
15. ? Malignant disease of stomach.
29. Gastritis.
31. Dysentery.
35. Hæmatemesis. Gastric ulcer.
39. Carcinoma of pylorus.
45, 46, 26, 22, MARY 1, 15. Gastric ulcer.
19. Ascites. Malignant disease.
30. Ascites.

Genito-Urinary.

PHILIP 3. Acute nephritis. Hæmaturia. Retinal hæmorrhage.
8. Acute nephritis.
10. Polyuria. Fits.
12. Diabetes mellitus.
25. Acute tubal nephritis.
38. Chronic tubal nephritis.
STEPHEN 11. Acute nephritis.
14. Tuberculous kidney.
24. Diabetes mellitus.
MARY 4 & 5. Chronic nephritis.
34 & 39. Diabetes mellitus.

Respiratory System.

PHILIP 21. Chronic bronchitis and emphysema. Pleurisy.
53. Left pleuritic effusion.
STEPHEN 13. ? Phthisis.
18. Pleurisy.
27. Pleurisy.
MARY 27, 43, 3. Empyema.
PHILIP 28. STEPHEN 26. MARY 37, 39. Phthisis.

Miscellaneous.

PHILIP 2. Tuberculous disease of hip.
11. Addison's disease.
32. Tonsillitis.
STEPHEN 37. Plumbism.
21. Gout.
28. Psoriasis.
PHILIP 6, 36. STEPHEN 4, 38. MARY 3, 6, 20, 32, 35. Typhoid fever.
PHILIP 16, 27, 37. STEPHEN 40. Acute rheumatism.

CASE UNDER DR. GOODHART.

MARY.

24. M. N., æt. 4. Admitted for weakness of the legs, August 21st, 1894.

History of fainting fits from two years of age till nine months ago. Fits lasted about 20 minutes, and during them patient would clench her fists, turn up her eyes and turn blue.

The child was well up to a week ago, when, on the 14th, her mother noticed she staggered about in walking, and once nearly fell under a cart. During the week she has been getting worse, and has retched several times after food, but brought up nothing. She has complained of headache, but eaten and slept well.

On admission.—Patient was well nourished and had a bright colour; was intelligent, and could see, hear, and speak without difficulty. Temperature 97·2. Pulse 140. Respiration 20.

Eyes.—Pupils moderate size; react readily to accommodation, but *not* to light. There was nystagmus.

Reflexes.—Plantar, abdominal and epigastric reflexes are present. Knee-jerks absent. No ankle clonus.

Marked ataxy of legs. She cannot walk without support, and then she places her feet wide apart, and oscillates backwards and forwards and from side to side. Her head falls forward on to her chest. When sitting up, she sways about or leans back on her hands. No ataxy of the arms.

No incontinence of urine or fæces, or tâche cérébrale.

There is weakness of both legs.

Heart sounds.—Normal. The pulse soon slowed down to 110.

Lungs.—Normal.

Urine.—Sp. gr. 1022; acid. No albumin, blood, or sugar.

August 22nd. Abdominal, epigastric, and scapular reflexes absent.

25th. Weakness of legs more marked, especially left. Grasp feeble, especially left. Pupils react to light. No nystagmus.

27th. *Eyes.*—External recti paralysed; inferior recti feeble. As antitoxin could not be had, patient was treated with Liq. Strychninæ ♏ i., t.d.s.

28th. Patient drags left leg in walking. Inferior recti all right again.

30th. *Electrical reactions.*—Contractions with Faradic; none at all with galvanic currents. Patient regurgitated some milk through her nose, and passed some also down her trachea. Loud râles and rhonchi over left

chest, back and front. Respiration sighing, and chiefly thoracic. Patient can hardly stand; left side much weaker than right. No history of sore throat or other illness could be obtained from the mother. *Urine* normal. *Treatment.*—Subcutaneous injections of Strychnine, and Digitalis in enema. Fed by nutrient enemata.

31st. Respiration varying between 20 and 36. Pulse 100; occasionally intermittent.

September 1st. Pulse 130. Respiration 36. Coarse râles over right chest. Finer râles over left apex and tubular breathing. Later in the day there was tubular breathing at right base. At five o'clock she became cyanosed, and oxygen was administered. During the evening she became worse, and was asphyxiated about 11.30. Pulse stopped about two minutes before the respirations.

Diagnosis.—Diphtheritic paralysis.

Post-mortem report.—There were some patches of collapse in the lungs.

Cases under Dr. Taylor.

Stephen.

10. W. L., barman, æt. 40. Family history good. No previous illness of note; but history of alcohol. Became ill about 18th of May, 1894, with lassitude and pain in the back, accompanied by dark colouration of urine, yellowness of skin, absence of colour in motions; a fortnight later the skin began to itch.

Admitted to John ward (Dr. Pitt), June 18th. Skin and conjunctivæ markedly yellow, covered with a rash, especially the extremities. Urine, bile pigment and trace of albumin. Motions clay coloured. Liver, enlarged to within two inches of umbilicus, smooth, hard, not tender. Heart and lungs normal. No cerebral symptoms. No pain in abdomen. On Tinct. Jaborandi ɱxxx., t.d.s., he became better; urine became normal; motions were coloured. Rash disappeared; itching became less; liver decreased in size.

Patient went out June 27th, but on returning to work the former symptoms all returned. He was admitted into Stephen, August 13th.

On admission.—There was well-marked jaundice, but no rash, only marks of scratching. Urine, bile pigment; no albumin. Motions colourless. Liver within two inches of umbilicus. Temperature normal. Pulse 64, normal.

Jaborandi again given, but without effect so far. The irritation prevents sleep, so he is bathed night and morning with Lot. Acid. Hydrocyan. He now suffers from diarrhœa.

Patient states that he has lost about 3½ stone in weight since the commencement of the illness; also, that he has never had any acute abdominal pain in his life.

Diagnosis.—? Malignant growth pressing on duct. ? Cirrhosis. ? Impacted gall stone.

11. C. W. H., æt. 53, clerk. Previous history.—Patient had a stricture, followed by inflammation of the bladder, twenty-five years ago. There is a well-marked alcoholic history. Present illness—At the beginning of July patient had a cold; on July 12th patient's urine became dark-coloured, and his feet began to swell. Later on his legs scrotum and abdomen became swollen. His micturition became frequent and scanty, and he became short of breath. Patient was admitted on August 14th for swelling of legs.

On admission.—Patient's feet, legs, scrotum and penis are markedly œdematous. *The abdomen* is distended, dull in flanks, and resonant in middle. A distinct thrill can be obtained. *Urine:* sp. gr. 1027, dark colour, acid reaction. *Blood:* albumin 5 parts per 1000, urea 1 per cent.; deposit contains granular and blood casts and corpuscles. *Heart:* accentuated second sound. *Pulse:* compressible, small. *Lungs:* right base dulness, absence of breath sounds, and T.V.F. *Eyes:* a white patch exists on the retina. The œdema of the legs has diminished, but the abdomen remains very much distended. Both bases have now become dull. The pulse has become hard and incompressible. Patient has had slight hæmatemesis once, August 20th. On August 31st, patient became delirious in the evening, and has remained so more or less since. At the same date an erythematous rash was observed on the front of the legs and thighs, on the extensor surface of the forearms, and at the upper part of the abdomen on either side. It appears as small red spots, not raised from the surface, these coalesce and form patches. It causes no irritation.

Diagnosis.—Acute nephritis.

In the Surgical Wards.

Cases under Mr. Howse.

Charity
5. Epitheliomatous ulcer of palm of hand. Amputation. Glands in axilla.
6. Divided tendon of rectus femoris. Reunited by operation.
7. Tubercular knee. Old excision.
8. Carcinoma mammæ. Broncho-pneumonia. Shortly to be operated on.
9. Hip-joint disease. Dorsal dislocation.
—. Left mastoid abscess.
10. Double talipes equino-varus. Phelps' operation.
—. Pott's disease. Psoas abscess. Operation.
11. Intra-capsular fracture of neck of femur.
12. Scirrhus carcinoma mammæ. Amputation.
13. Intra- and extra-capsular fracture of neck of femur.
15. Fractured tibia. Croft splint.

Cot C.
Green-stick fracture of femur.

16. Chronic ulcers on leg. ? Cause.
17. Strangulated right femoral hernia. Operation.
18. ? Impacted fracture of neck of femur.

Cot D.
Ruptured eye-ball. Excision.

Charity 19. Scald on legs.
20. Strangulated right femoral hernia. Operation.
Cot E. Webbed fingers following a burn.

Cases under Mr. Lucas.

Job.

1 and 22. Hæmorrhoids.

4 and 21. Varicocele.

5. Semi-membranosus bursa. Excision.

6. Æt. 15. An old case of necrosis of the femora. A 1 in 20 carbolic compress was put on both legs about 5 p.m., August 29th. At 2 a.m. the same night, the boy was found semi-comatose; a pulse of 200 scarcely to be felt; frequent vomiting; no reflexes; limbs flaccid. With stimulants he slowly improved, and next morning there was carboluria and a temperature of 103, and the vomiting continued for nearly 48 hours. The carboluria not being seen, he was supposed to have had an epileptiform fit. On September 3rd, a similar compress was put on about 11 a.m. At 3 p.m., just before operation, he was somewhat collapsed; a temperature below 95, and vomiting. Operation was again postponed. Carboluria the same evening suggested the cause of both attacks. Unfortunately, careful observations were not made. The lowest temperature on both occasions was not known, nor the first appearance of carbolic acid in the urine, nor the earliest onset of symptoms. The sinuses are very small, and absorption must have been mainly through the skin.

8. Lateral sinus thrombosis resulting from otitis media. Internal jugular tied. Sinus exposed and clot removed.

13. Æt. 22. Fell 41 feet in November, 1893, fracturing his right os calcis. Was put up in plaster. Has had great pain in the foot ever since, disabling him from work.

On admission.—The left arch has dropped somewhat. There is some œdema and swelling about the ankle, slight grating on movement, and the apex of external malleolus impinges on the os calcis, owing to external rotation of the anterior fragment, and consequent union in this position.

August 29. Mr. Lane divided the os calcis with a chisel near the old line of fracture, and after much trouble the pieces rotated into their normal relations, and were fixed with a screw. There has been primary union, and it remains to be seen whether the foot is as good as before the accident.

16. Stricture of urethra. Internal urethrotomy.

17 and 23. Hydrocele. Radical cure. Excision.

18. Stone in bladder. Suprapubic lithotomy.

19. Æt. 23. Admitted for symptoms of stone. Mr. Lucas found it too large to crush, and removed it by suprapubic lithotomy. The stone, composed of uric acid, measured $2\frac{1}{2}$ by $1\frac{1}{2}$ by $1\frac{1}{4}$ inches, and weighed $2\frac{3}{4}$ ounces. The bladder was stitched up, and the patient is doing well.

20. Æt. 45. A pedunculated tumour of bladder, which could be felt plainly per rectum. Mr. Lane removed it with Lovenberg's forceps through a suprapubic wound, and stitched up the bladder. Primary union, and patient up on the tenth day.

22. Æt. 62. An enlarged prostate. Mr. Lane removed the middle lobe through a suprapubic wound, and stitched up the bladder. There was much hæmorrhage blocking the catheter repeatedly, and eventually causing the wound in the bladder to burst open. Patient went slowly downhill, and died from uræmia eight days later. Post-mortem showed bad kidneys, but the obstruction was completely removed.

Lydia.

10. Congenital dorsal dislocation of both femora. False joints made under superior iliac spines. Put up in double Thomas.

12. Æt. 55. Admitted August 19th, much emaciated, for pyloric growth of three years; very freely moveable.

August 23rd. After the stomach had been well washed out in the morning, at 1.40 p.m. Mr. Lane opened the abdomen, and pulled the growth out of the wound. The large and small omenta were ligatured and divided in sections, freeing the growth, and several malignant glands dissected out, a continuous silk suture was passed to-and-fro through the stomach walls one inch internal to the growth, and the intervening portion divided, sewn up, inverted, and finally secured with a Lambert, which also included the first row of sutures, thus putting them inside the stomach cavity. The duodenum was next exposed, clamped and divided, and male half of the button fixed in usual way in the open cut end. A purse-string suture was put in the anterior surface of the stomach, an incision made within it, and the female half of the button inserted, and the two at once joined up. The abdomen sewn up, and sterilised dressings applied. Sterilised sponges used during the operation, which lasted one hour and fifteen minutes, including the anæsthetic.

The result was as follows: Patient vomited steadily small quantities of very foul-smelling fluid until her death on the 27th. She retained her enemata well, and had no pain or rise of temperature. Death was apparently from exhaustion, or septic absorption of the stomach contents.

The post-mortem showed the operation to have been a brilliant success, everything being perfect, and the union already firm. The operation well showed how Murphy's buttons have simplified abdominal surgery. The duration, viz., one and a quarter hours, short as it was, would have been considerably less without the time spent in dissecting out infected glands.

14. Ischio-rectal abscess. Necrosis.

15. Burn. No symptoms of shock.

16. Burn. Pyrexia; baths. Impetigo glands. Broncho-pneumonia. Convalescent.

Charity.

2. Plastic operation for cicatricial tissue on face and ectopion.

Cot A. Acute retention. Pus in urine. ? Abscess bursting into urethra.

4. ? Kidney. ? Liver.

Cot B. Double congenital inguinal hernia. Radical cure.

CASES UNDER MR. SYMONDS.

LYDIA.

1. Varicose veins of upper and inner part of right thigh and labium, dating from first pregnancy nine years ago. They had caused so much pain and inconvenience as to interfere with the patient in earning her livelihood as a factory-hand. They have been removed, and are healing under the first dressing.

Cot A. Caries of cervical spine without abscess or pressure symptoms.

5. Tuberculous abscess in upper part of forearm over the back of the ulna; source not identified. The patient has phthisis.

8. Epiphysitis at lower ends of both femora with secondary synovitis of knee-joints, in a boy of six. Probably syphilitic.

9. Angeiomatous tumour in flank. The tumour is congenital, and has not grown very much in the five weeks since the child was born. The tumour, which is three and a half inches long, two and a half inches broad, and projects one and a half inches from the surface, is partly solid, either sarcomatous, fibromatous, or lipomatous. It is apparently in the subcutaneous tissue, and does not involve the muscles of the abdominal wall.

19. Galactocele. A hard rounded tumour close to the nipple of a woman who has lately been suckling. The tumour was freely moveable, and thought to be an adenoma. At the operation it was found to be composed of inspissated milk of the consistency of stiff putty, and the solid feeling of the tumour was thus accounted for: compare the specimen of Mr. Binkett's referred to in Wilks' and Moxon's Pathology. The specimen has been sent to the Museum.

JOB.

11. Epithelioma of penis and glands in the groin.

PHILIP.

Private Room.—Large uterine myomata. The principal part of the tumour was in the uterine wall, and had elongated the cavity of the uterus enormously. There were also two large sub-peritoneal fibroid tumours growing from the surface of the main tumour. Hysterectomy.

LUKE.

2. Laryngeal warts. Several large papillomatous masses have been removed already. They grew from both cords and the base of the epiglottis.

5. Chronic enlargement of inguinal and iliac glands, following on acute inflammation from absorption at a sore on the foot.

8. Syphilitic orchitis.

10. Cock's operation for stricture and urinary fistula. The urethra with difficulty allowed the passage of a ½-catheter, and is now being dilated.

11. Nasal polypi. Complete nasal obstruction, with constant headache for years. A very large number of polypi have been removed with the snare.

16. Hypochondriacal pain following operation for varicocele. It is proposed to stretch the cord.

17. Œsophageal stricture.

18. Gummatous inflammation of bursæ in front of knee.

20. Nævus of lips, tongue and cheek. Electrolysis.

ACCIDENT.

22. Æt. 47. Admitted August 20th, for transverse wound of dorsum of foot, over the metatarso-phalangeal articulations of the three middle toes; the dorsalis pedis was divided. Patient has been a hard drinker. The wound was stitched up. No sugar or albumin.

On August 24th, it was found that the three toes were gangrenous, and that the foot was œdematous, especially round the ankles, and the skin looked red and angry all over. The question of amputation was at once raised, but Mr. Lane decided to try sulphur first, and the foot was accordingly dressed with sulphur and glycerine paste.

25th. The three toes were removed, and the process appears to be spreading to the great toe, and the foot generally is no better. The temperature is only slightly raised.

26th. A marked improvement set in to-day; there is more sensation than there has been, the œdema has gone, and the edges of the gangrenous portion look more healthy.

September 5th. The improvement has continued, and the process has been completely stopped, apparently by the sulphur, which has been applied daily, and patient keeps his foot with the loss of the four outer toes only.

Notes on Dr. Shaw's Demonstrations in Pathology.

CONGENITAL HEART DISEASE.

(*Continued from page 285*).

Pulmonary Artery.

Embolus in [21] (1450[29, 41, 64, 65]).

Thrombosis [143] [195] (1450, 1450[40 & 55]), often starting in the branches and spreading upwards. In this position thrombosis is due either to defects in the blood or in its rapidity, and not to disease of the vessel wall, as atheroma is rare here.

P. M. clotting (1450[57]).

Results of increased vascular tension, due either to chronic bronchitis and emphysema or to mitral stenosis:—

(*a*) Dilatation (1450[44, 46 & 47]), often without any atheroma and without producing incompetence.

(*b*) Atheroma (1450[63, 69], 3348).

Invasion of pulmonary arteries, by—

Aortic aneurysm (1450[25]).

Tubercle (1450[62, 66A]).

Cancer (1450[67, 68]).

Aorta.

Thrombosis (1471[50 & 51], 1456[15]), not as common as in pulmonary artery as circulation is so rapid.

Embolism, still more rare. Sometimes by a clot from aneurysm of heart. At the bifurcation from an aneurysm or clot higher up.

Injury—Fish bone (1451).
Tracheotomy-tube.
Severe crush (1452[10. 11 & 60]).

Narrowing—

(*a*) General, in chronic mitral stenosis, the whole body remains small.

(*b*) Local, coarctation (1450[80 & 90]), just at point of entrance of ductus arteriosus; probably congenital; development of anastomosis by large superficial arteries.

Kinking, due to angular curvature of spine (1450[74]).

Tumour (1470[50]), generally syphilitic, surrounding the artery.

Atheroma, due to (1) hard work of all sorts, including hard work to heart as in chronic Bright; (2) syphilis; and (3) endocarditis (1452[75], and 1455[50]).

Stages of—Fatty patches, small areas of a different colour to the rest of inner lining of artery.
Calcareous plates.
Ulcers.
Generally all exist together.

Effects of—Dilatation.
1. General (1459), rarely produces any symptoms of pressure.
2. Local (aneurysm).

Thoracic aneurysm—

(*a*) Pressing upon—
1. Arteries: pulmonary (1480[57]), vessels of arch (1486[80]).
2. Heart (1479), generally the auricles.
3. Veins, *e.g.*, superior vena cava (1480[66]); the superficial veins become dilated.
4. Nerves: recurrent laryngeal (1480[37]), generally the left, vagus, brachial plexus, phrenic.
5. Respiratory organs: trachea (1480[37]), most marked in aneurysm of transverse arch. bronchus (1486[80]), especially the left. lung (1489[51]).
6. Œsophagus, not at all common (1480[37]).
7. Bones: sternum and ribs (1485[55]), spine (1480[37], 1490[25]).

(*b*) Opening into—pericardium (1480[11]). pleura (1490[25]). externally (1485[55]).

Dissecting aneurysm (1452[24, 25 & 26]).

Cured aneurysm (1480[95]).

Abdominal aneurysm—

Trunk (1493[5]).

Branches (1495[50], 1504[46A]).

1. Obstructing arteries (1493[5]).
2. Obstructing veins (1495[50]).

Coronary artery (1500[10], 1500[64]).

Superior vena cava, obstructed (1521[27], 1521[52]) [690].

Inferior vena cava, obstructed (1521[65], 1522, 1522[40]).

NERVES.

Injury—Gunshot (1616[20]).
Laceration (1620).
Crushed (1615[5]).
Divided by surgeon (1619[10]).

Inflammation: nerve may be a little thickened and red. Only detected microscopically. May lead to atrophy.

1. Single, due to a local cause, *e.g.*, of facial from inflammation spreading from middle ear.
2. General: due to some poison circulating in the blood, *e.g.*, alcohol, lead, diphtheria.

Atrophy (1613, 1613[25 & 50]): nerve is exceedingly small.

Causes:—

1. Cutting off of fibre from nutrient centre; degenerative atrophy.
2. Inflammation, consecutive atrophy.
3. Primary atrophy.
4. Abolition of function.

Growth.

Fibromata and neuromata (1614, 1614[51], 1617). Single or multiple.

Malignant (1620[12], 1620[45]): actually arising in nerve, extremely rare. Myoma are supposed to occur. Often involved by invasion. Pressed upon also by any tumour, *e.g.*, aneurysm.

SPINAL CORD AND MEMBRANES.

Injury.

Fractures and dislocations—
Contused cord (1560[64]),
Divided (1561[20]).
Hæmorrhage, internal (1561[60]),
external (1561[50]).
Hæmorrhage internally sometimes found in paraplegia immediately following injury without any other obvious lesion at all.

Stabs.

Inflammation.

(*a*) Meningitis, acute (1562[40]),
chronic (1562[30 & 70]),
tubercular (1562[26 & 66]),
syphilitic.

Pacchy-meningitis, not idiopathic; if acute, always from extension, *e.g.*, from a necrosed rib, bedsore.

Septo-meningitis, recognised by pus beneath the dura mater, and held in the meshes of arachnoid, so that it is not easily washed off with water. Sometimes not suppurative, and then nearly always tubercular and associated with tubercular meningitis of brain.

(*b*) Myelitis—

Acute (softening): post-mortem softening or injury liable to be mistaken for acute myelitis.

Chronic (hardening) (1562[18]), commonly so from onset, or may follow acute. If whole cord affected = ordinary chronic myelitis; if special groups of fibres affected = sclerosis (1562[82]).

Passim.

On the retirement of Sister Clinical, five months ago, seventy-three of the old Clinical Assistants clubbed together with a view to presenting her with a memorial of their experience of Clinical wards, an experience which stands out pre-eminently among our Hospital appointments. We are pleased to say that Miss de Wet was very gratified with the memorial—a travelling repeater clock, which was handed to her at Ascot by a deputation. Miss de Wet has entered an enclosed Anglican Order at Ascot Priory. The Order supports an orphanage, and a large convalescent ward, in which are to be found several of Guy's patients.

The Clinical Research Association, of 5, Denman Street, S.E., has sent us its prospectus, from which we learn that the profession generally is to be afforded opportunities which our readers have for some time enjoyed in the use of our "Pathologist Column." The intention of the Association appears to be to run it on lines precisely parallel to our own, and its aim is to enable practitioners to gain assistance in their diagnosis and treatment, by obtaining bacteriological, chemical, or histological reports on morbid products, at low fees. We are glad to welcome this new enterprise, not because we wish to lose the support of our readers, who will, doubtless, trust to the Gazette's Pathologist as heretofore, but because we think there is a real need for such help among practitioners generally. We have already been asked to undertake work from sources outside our own circle of readers, and have been obliged to decline, because such enterprise might very easily outgrow the limits of our capabilities. While, therefore, we should like to call attention to the fact of our own priority in the matter, we gladly make this reference to the existence of the Clinical Research Association, and wish it every success. The names which appear upon the prospectus are a sufficient guarantee that the work will be efficiently carried out, and the fees quoted are certainly as moderate as possible.

The Hon. Secretaries of the Students' Club have again requested us to announce that a House Dinner will be held on October 1st next, when Mr. Durham, President, will occupy the Chair. Tickets, price 3s. 6d., which are limited to 110, may be had on application, by letter, to the Assistant Hon. Secretary of the Club, or to Mr. Batten, in the Dining Hall. It is hardly necessary to mention that the Pupils' Physical Society meets the same night, after the Dinner, in the Anatomical Theatre, when Dr. Wilks will take the Chair. A paper will be read by Mr. E W. Lockhart Stephens, on "Medical Education in relation to General Practice."

We have received a paper on "The Relationship between the occurrence of Diphtheria and the movement of the subsoil water," read by Mr. Matthew Adams, F.R.C.S., at the Eighth International Congress of Hygiene and Demograph, on September 4th last, at Buda Pest. The paper is full of interest on a matter of what doubtless will be considered of vital importance to the health of the community in the future. The account is a continuance of Mr. Adams's contribution to the Seventh International Congress, and represents three additional years' observations upon the movements of the subsoil water and the occurrence of diphtheria in the Maidstone district. We hope to publish, on another occasion, some portions of his valuable paper, which pressure on our space compels us to hold over for the present

The New Catalogue of the Pathological Museum, edited by Dr. Perry and Dr. Shaw, is announced as we go to press. We hope to give a lengthy notice of this excellent work in a later issue.

Pemphigus v. Erysipelas complicated with Variola.

ON July 3rd, Mrs. K., æt. 53, was removed to St. William's Fever Hospital, Rochester, on receipt of notification that she was suffering from erysipelas complicated with small-pox. The small-pox wards had been long empty, fumigated and cleansed. The usual preventive steps were taken by the sanitary authority with regard to the home and surroundings of patient.

On examining the case doubts at once arose, as I had never seen small-pox in such a form. The medical attendant, however, in consultation somewhat shook my opinion through the fact that "he had seen and treated many cases of like nature in India and elsewhere."

The history was very meagre. Three days before admission she had "blisters" and some hard "boils" on her face, a few on her arms and wrists on the outer sides. These rapidly enlarged and filled with fluid. This had been explained as due to the kidney disease. The same conditions continued, crops of fresh bullæ appeared—many larger than walnuts. On or about the third day the bulla either burst or commenced to shrink and crusts to form. The appearance of the patient on the 15th may be seen in a photograph,* taken hurriedly, and in which the writer appears as a ghost, and Mr. W. Buchanan is looking attentively at the patient's tongue. The woman became gradually worse, sleepless, refused nourishment, and diarrhœa set in, terminating the case on the 23rd day.

The appearance of blebs on the face of a person suffering from alcoholism (gin was the only "nourishment" the patient enquired after) could no doubt be mistaken for erysipelas, especialy as Pemphigus is rarely met with. In one or two "boils" there was at first a suspicion of umbilication. As Medical Officer of Health I was unable to trace the source of small-pox. This fact, however, was only of doubtful service at the time, because cases will occasionally crop up of which little or no clue to the source can be discovered. Nevertheless, it was useful when considering the pros and cons.

1. No history of infection.

2. No other cases occurred. (The patient had been visited by a good many relations and neighbours, old and young.)

3. The concurrence in the opinion of all the medical men, save one, that it was not small-pox.

The temperature chart affords but little information except that it is not what one would expect in an ordinary case of small-pox.

WILLIAM WATSON.

* We regret we received this photograph with the temperature chart too late for reproduction.—ED.

Birth.

WORNUM.—On August 18th, at College Terrace, Belsize Park, Hampstead, N.W., the wife of George Porter Wornum, M.R.C.S. Eng., of a son.

With Dr. Perry in the Skin Department.

CASE I.—Young man with patches of eruption on forearms and backs of hands, also about knees; small red areas covered with shiny scales. Says he has had it several times before. Very irritable. Diagnosis: psoriasis. Name means "the itch," but majority do not irritate. Variety is psoriasis guttata, or psoriasis nummularis, merely according to size of patches. Note position. Scaly eruption on hands makes one think of syphilis; this much more common on the palms, where psoriasis is rare. The history of several attacks, and the irritation, are against syphilis. Rather more common in men than in women; occurring in the latter, the disease is aggravated by pregnancy or lactation. It commonly occurs before 25 years of age, and is practically never seen under one year. *Treatment.*—Arsenic, as the liquor, with a bitter. Sometimes a patient who will not take the alkaline form, will take it with an acid. Arsenic can be given in pills. In using the liquor, gradually increase dose, beginning with a few minims. First poisoning symptoms, the eyes are irritable, and patient is inclined to rub them. Unusual nervous symptoms, numbness, etc., show incipient poisoning. Certain skin diseases are apt to arise in course of treatment. Eczema Arsenicale, a vesicular or pustular eruption is not uncommon. Herpes Zoster may be met with (Hutchinson). Other drugs: the iodide of potassium has some reputation, even when no syphilitic taint is present. One might fall back on it if arsenic fails. Thyroid extract coming to the fore, but extensive trial has not yet been made of it. About seven or eight weeks are required to effect a cure with arsenic in a well-marked case. Remember that psoriasis in alcoholics may get rapidly well when the indulgence is checked. Of ointments, the tarry preparations are much used. Ung. chrysarobini is good, but has two drawbacks; it stains linen, etc., so that old sheets must be used, and it sometimes sets up an acute dermatitis, especially on the face. Dr. Perry often uses the pigmentum chrysarobini for small isolated patches of psoriasis; it does not stain. Paint, and, as soon as the film comes off, paint again.

CASE II.—Man complaining of "sore head." The first thing one notices is that scars have been left; therefore we dismiss eczema and impetigo, which do not scar. Lupus and tertiary syphilis are the most common scarring affections of the head. This patient is 35 years old, and has had it eight months. Late age for lupus; moreover, the scar is depressed in this case, and has small deeper fossæ in its base. The scar of lupus erythematosus is quite superficial.

CASE III.—Youth finds his hair is falling off. This general alopecia must be distinguished from alopecia areata, in which patches of absolute baldness occur on head well covered with hair, in this case probably secondary to seborrhœa. Syphilitic alopecia is a general thinning—not a patchy condition—and in it the scalp is commonly tender. This form is common after the

specific fevers, and the prognosis is then good. Alopecia areata, or area, is characterized by complete absence of hair in recent case, or a few stumps with thickened ends, like notes of admiration, occur at margin of patch. An old patch in which healing has commenced is covered by downy hair, which is thus a good sign, and warrants a more favourable prognosis. It is believed that there are two forms: the neurotic or trophic, and the parasitic. Difficulties exist in the way of each view. The distribution does not follow the course of a nerve in the first place, and in the second the parasite, though diligently searched for, has never been discovered. Patients sometimes say they caught the disease from an animal—*e.g.*, a horse. Quinine was introduced in treatment on the parasitic view.

Notes on Small-Pox.

By Stephen Floyd, M.B. Lond.

(*Continued from page 290.*)

Case V.—A rapidly fatal hæmorrhagic case.

John T., æt. 31. Vaccinated in infancy, six scars; total area 1·22 square inches. No foveation.

August 4th. Headache and sickness.

8th. On admission, very marked hæmorrhagic rash in axillæ and over lower part of abdomen and Scarpa's triangles. The rash continues down the flanks. Some of the hæmorrhages are as big as a sixpence. There are no signs of the specific eruption. He got rapidly worse, and passed blood in his urine and per rectum, and died on August 10th, at six a.m. He developed several large subconjunctival hæmorrhages, and just before death, a very large hæmorrhagia, almost covering the front of the lower part of the abdomen.

The case is interesting, as the hæmorrhagic rash at first occupied the seat of an ordinary primary rash, and might have been mistaken for it. He complained, as these cases often do, of terrible pain about the region of the xiphoid cartilage, which could only be relieved by morphia hypodermically.

Case VI.—To show the modification produced by recent vaccination.

George G., æt. 2. Vaccinated, for the first time, July 17th, successfully in two places. Three brothers and sisters in the Hospital.

July 18th. Headache; backache.

21st. Eruption on face.

24th. Admitted with scanty vesicular rash. The vesicles, though well developed, dried up in a few days, without becoming pustular, and the child soon got well.

Case VII.—A fatal case.

George B., æt. 24. Said to have been vaccinated, but no cicatrices to be seen.

July 23rd. Backache.

25th. Eruption on face.

30th. Admitted with very abundant flattened rash and hæmorrhages into a few of the papules. The patient gradually got worse. He was extremely restless, and suffered greatly from insomnia. His temperature rose to 105·5 on the sixteenth day of the disease. Sponging was repeatedly resorted to when temperature reached 103·5, and was always successful for a time; an hour or two of sleep often being obtained by this means when drugs had failed. Towards the end he suffered from obstinate diarrhœa. He took nourishment well up to the last. He died on August 9th.

Case VIII.—A case of small-pox complicated by erysipelas and parotitis.

Thomas L., æt. 5. Vaccinated in infancy unsuccessfully.

July 23rd. Headache.

24th. Rash on face and legs.

25th. Admitted.

August 11th. Both sociæ parotides began to swell. Some of the upper cervical glands are large and tender.

13th. Very much better.

14th. Well-marked erysipelas of face.

19th. Erysipelas has cleared up on face, but scalp is now affected. No albumin in urine.

21st. Temperature normal. Erysipelas very much less.

I should think that the parotitis might very well arise by direct infection from the mouth.

Case IX.—An abnormal rash.

Thomas W., æt. 31.

July 20th. Headache and backache.

24th. Eruption on arms.

25th. Admitted. Scanty papular eruption on face, arms, legs and trunk. Each papule has a deeply-red halo round it. The whole body is covered with a roseolous eruption—best marked on chest; it fades on pressure.

This patient got rapidly well. The case is interesting, as many of the hæmorrhagic cases start with an universal roseola.

I have noticed a well-marked roseola on the arms of men who work in the open air with their sleeves tucked up.

We had a case in recently of a boy who had been signed up by a medical man as a case of scarlet fever, and was transferred to us from a Fever Hospital. He was really suffering from the primary rash, and certainly looked uncommonly like a case of scarlet fever. The error might have been avoided however, as the petechiæ were almost confined to the axillæ, flanks, abdomen, and Scarpa's triangles. The boy complained of headache and backache two days before, but no sore throat. The specific eruption came out the next day, and the case ran an ordinary course.

Appointment.

Coulson, J. E., L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Medical Officer to the Workhouse and Infirmary of the St. George's Union.

From our Cape Correspondent.

THE following brief notes of cases may prove of interest to your readers :—

LEUCODERMA.—As is well known, this disease is far more common in the dark than in the white races. The case of a woman, æt. 40, who was suffering from cancer of the uterus, was remarkable for the extent of the surface affected. The disease had begun, when she was a young girl, on the chest, and now leaves unaffected only the face, the extensor surfaces of arms and forearm, and parts of the dorsum of hands and the fingers. But for this, she would pass as a beautifully fair white woman. Though the scalp is quite white, the hair remains black, contrary to what Crocker states to be the general rule.

HYDATID OF THE NECK.—A coloured girl, æt. 15, presented in the posterior triangle, a few inches above the clavicle, a smooth, loosely-fixed tumour, over which the skin was freely moveable. It appeared to be lobulated at one part, and it was thought to be either a lipoma, or possibly two glands enlarged with Hodgkin's disease. It had been noticed for four years. On removing it, it proved to be an hydatid of about the size of a goose's egg. The apparent lobulation was due to a constricting band of fascia.

PTERYGIUM.—This is as common here, especially among the dark races, as it is uncommon in England, and one sees cases of it almost every day among out-patients who come up for other diseases.

INFECTIVE DERMATITIS.—There has recently occurred in patients, who have been to the hospital for other reasons, examples of a universal dermatitis, of an apparently infective nature, corresponding in appearance to the cases described recently in London infirmaries. Four middle-aged men were attacked.

HÆMATO-THORAX.—This case occurred in a convict suffering from scurvy. He had spongy gums; painful swellings in the hams and legs, and was weak and ill. One day, while sitting up in bed, he suddenly fell back dead. His left chest was found full of pure blood, much of it clotted when the post-mortem was made. The collection of blood must have taken place very rapidly, as a few days before his chest was quite normal. No large vessel was implicated. I am indebted to Dr. Pauling, under whose care the case was, for these notes of it.

C. C. ELLIOTT.

New Somerset Hospital, Cape Town,
August 7th, 1894.

Marriage.

BRAITHWAITE—McCULLAGH.—On August 9th, at Trinity Wesleyan Church, Macclesfield, by the Rev. H. H. McCullagh, B.A., assisted by the Rev. C. B. McCullagh, B.A. (brothers of the bride), Charles Bernard Braithwaite, M.B. Lond., of Golcar, near Huddersfield, to Kate, third daughter of the Rev. T. McCullagh, of Macclesfield.

Clinical Aphorisms.

THE following remarks are only intended as hints to those just undertaking the responsibilities incidental to general medical practice, especially to any who may be obliged to see many patients in a limited time. Text-books will teach much and nature much more to those who care to learn, and although many of the subsequent statements are mentioned incidentially in various books, some are from my own observation, but all I have proved in actual practice, and I present them with all humility and diffidence :—

In all cases of acute tonsilitis examine the heart; the worst fatal case of pericarditis I ever had in a child began with simple tonsilitis.

Remember that with children rheumatic endocarditis often develops without any joint affection, the only symptom being pyrexia till murmur is heard. Also bear in mind that pericarditis may advance insidiously without obvious symptoms.

A chronic bruit may not be elicited till after the patient is made to exert himself.

A man may walk about with pneumonia far advanced, hence many cases of "found dead" among the poorer classes are proved post-mortem to be due to this.

Pneumonia occasionally exists in early stage without physical signs; the first physical sign of pneumonia may be limited deficient breath-sound. Also bronchophony can be elicited *before* crepitations are audible.

The pain of pleurisy (and pleuro-pneumonia) is very often referred by patient to either hypochondriac region. I have often seen this part of abdomen poulticed in these cases, whereas the mischief and physical signs are at back of lower lobe.

The first symptom of cervical caries may be cervical meningitis (I had one such who recovered), or a slough on pharynx resembling diphtheria.

Cases of cervical caries may advance considerably without much inconvenience to patient.

In all cases of acute (septic) periostitis or osteo-myelitis, diligently search everywhere for a recent abrasion or scar. It would seem that two factors are necessary in these cases, a surface for septic absorption and a local injury to bone, though the former may be small and the latter slight, and I believe with care you will *always* find evidence of both; since realising this, I have never failed to discover a sore: for instance, a boy with high temperature complained of acute pain and tenderness over inner tuberosity of *left* tibia; had been kicked there some days before; on searching, found recent sore on *right* heel caused by sock; it was acute osteo-myelitis of bone, and ended fatally with multiple pyæmic abscesses and pericarditis. Another child came with severe periostitis of whole of tibia; history of slight injury some days before symptoms set in, found sore on foot of same side.

Always keep in mind that diarrhœa in elderly people may be due either to scybala in dilated rectum or to malignant disease; also that carcinoma of rectum may

exist to end of case without any or with only partial obstruction.

Cancer of uterus may exist for some months without obvious symptoms. I have had a case sent for debility and *no uterine symptoms*; there was advanced carcinoma uteri, and she died a fortnight after. Another patient sent for change of air, who had had "sciatica," and been told there was nothing serious the matter (abdomen had been examined without removing stays by a consultant), had sudden severe hæmorrhage; uterus enlarged; advanced nodular carcinoma. Death in three months.

The premonitory and early symptoms of a disease may be very different from the classical.

With vesical calculus, severity of symptoms are not in proportion to size of the stone.

Carefully examine the chest of any patient over middle age, *with even slight blueness of lips*, though symptoms may seem trivial. It was just by noticing this that I once avoided a serious error of careless diagnosis, and I have found it a useful rule since. A man complained of slight pain over sternum which I thought probably dyspeptic, but, noticing lips, I examined carefully; found systolic murmur over manubrium sterni, no increased dulness, etc.; thought probably aneurism. Patient found dead in bed two mornings afterwards, and I was struck then by extreme cyanosis of face. Post-mortem—large aneurism of arch of aorta which had burst into pulmonary artery through very thin partition; there were other sacculated aneurisms in neighbourhood (I sent specimen to Dr. Shaw, and believe it is in the Guy's Museum).

An anæmic female patient may never tell you she has a small bleeding hæmorrhoid; think of this when medicines have failed.

Never give anæsthetic if you "feel a bit seedy."

Above all, remember Sir William Jenner's remark: "*More, many more, mistakes are made by not looking than not knowing.*"

Southsea. E. WILLMER PHILLIPS.

GUY'S HOSPITAL RUGBY FOOTBALL CLUB.—At a General Meeting of the Guy's Hospital Rugby Football Club, held in the Surgical Classroom on Tuesday, 28th August, Dr. J. H. Bryant taking the chair, owing to the unavoidable absence of the president, J. N. C. Davies-Colley, Esq., the following rule was carried unanimously:—"The colours of the club shall be those of the Clubs' Union. The uniform of the club shall consist of blue and orange jersey and stockings, with blue knickers. *The jersey* shall have a white collar, and shall consist of blue thread with horizontal half-inch orange stripes, two inches apart, encircling the jersey. *The knickers* shall be all blue. *The stockings* shall be blue with two half-inch orange stripes, one running round the upper edge and the other encircling the stocking two inches from the edge.—H. D. DUDGEON Hon. Sec.

Some Operations of Surgery.

THIS account deals with some operations performed by Samuel Sharp, Surgeon to Guy's Hospital, 1733–1757, recorded in his "Treatise on the Operations of Surgery," published in 1739; it was the *first* book on Surgery written in English. The treatise in question contains a dedication to "William Cheselden, Esq., Surgeon to Chelsea Hospital," to whom the author was "chiefly indebted to the advantage of an education, for whatever knowledge he could pretend to in surgery," and an exhaustive preface on the nature and treatment of wounds, abscesses, and ulcers. The treatise then proceeds to deal in thirty-seven chapters with the operations. The two earliest chapters deal with sutures in general, and with the suture of tendons respectively. The author describes of sutures—the interrupted, the Glover's, the quill'd, the twisted, and the dry sutures. He recommends, as the most useful, the interrupted and the twisted, and ridicules the dry suture as "only a piece of plaster applied in many different ways to re-unite the lips of a wound." A detailed description of suturing by interrupted suture is next given which does not materially differ from that at present in vogue. He then proceeds, "the most useful kind of knot in large wounds is a single knot first, over this a little linen compress, on which is to be made another single knot, and then a slipknot;" in "small wounds" the "double knot alone" is sufficient. In the suture of tendons the surgeon condemns the practice of entirely dividing a partially separated tendon before performing the suture as impolitic, as "the inflammation will be in proportion to the wound, and a small wound is certainly more likely to recover than a large one." He maintains that the joint should be moved to the best possible advantage of the divided tendon and kept in that posture.

"Of the Gastroraphy," the operation of suturing a "wound of the belly" complicated with another of the intestine. The operation can only take place when the bowels fall out of the abdomen, "and we can see where the wound is, or how many wounds there are." What was thought to be the imperative duty of the surgeon then, would, we fear, be considered nothing short of criminal in these days of asepsis. For we are told that "if it happens that the intestines fall out unwounded, the business of the surgeon is to return them immediately without waiting for spirituous or emollient fomentations."

"Of the Bubonocele."—Irreducible, inguinal, or scrotal hernia.—In cases where the herniæ are reducible, they may be secured by "steele trusses now so artfully made, that by being accommodated exactly to the part, they perform the office of a bolster, without galling, or even fitting uneasy on the patient." For want of judgment in the application of a truss, "we daily see trusses put even on *bubos*, indurated *testicles*, *hydroceles*, etc."

To prevent the trouble of wearing a truss, we learn that it was the practice of some surgeons to attempt doubtless what was meant for a radical cure. When

the intestine is reduced, the skin over the rings of the abdominal muscles is scarred with "a caustick of the size of half-a-crown." The cure seems to have been "often successful," the stricture of the cicatrix being sufficient to support the intestine in the abdomen. Mr. Sharp, however, deprecates its performance as "not answerable to the pain and confinement; for, if after this operation the intestines should again fall down there would be much more danger of a strangulation than before the scar was made." It would be interesting to know if this operation was among the earliest if not the first attempt at the radical cure of hernia. In directing attention to irreducible hernia (the Bubonocele), the author testifies to being "an eye witness of the cure of two patients who some time after the operation, when the eschar separated, discharged their fæces through the wound, and continued to do so for weeks in small quantities, when at length the intestine adhered to the external wound, and then was fairly healed." In gangrene of the bowel in umbilical hernia, it was no very uncommon thing for the gangrened intestine to separate, leaving a permanent artificial anus. Instances are mentioned of a scrotal hernia sloughing through the scrotum to form an anus; in one of which cases the patient made a good recovery. Happily, cases such as these seldom, if ever, occur, and are merely mentioned here to show under what serious disadvantages the operation of Bubonocele was performed by surgeons in the pre-antiseptic days of surgery; it was wonderful that good results ever occurred then, whereas now it is almost rare to get bad ones.

"De Examinationibus."

THE subject of examinations is one of many aspects. The subjects are *ditto*. Speaking broadly, there are two parts in the play; but usually a "utility" part is added for a "gooseberry." The title-rôle may be taken either by the candidate or by the examiner. The former (put so in alphabetical order), may be likened to a mirror wherein the latter sees, or rather should see, the reflection of his own bearing: a genial smile begetteth the like; a sneering lip may be truly reflected. The perception of the reflected image may not be pleasant to the reflecting body. As saith the poet, if we see ourselves as others see us, the result may be as uncomfortable in the present case, as no doubt it would have been to the subject of the poem.

Experience teaches us that a primary axiom in "Examinology" is that "l'examineur est né, il ne peut pas se faire." The difference, which is manifested to candidates, between various *gentlemen who hold the post of examiner* is most remarkable. One can and does frame his questions clearly, lucidly, and, moreover, in Queen's English—the reflected image of which, to return to our simile, is also clear and sharply focussed; another puts question after question in a vague manner—perhaps in English that would not bear the light of pen and paper. Thus many a question is so loosely framed that a number of distinct issues are raised; to answer all of which is obviously not the intention; but no inkling is given, either of what is really meant, or of the manner in which the query is to be attacked. It will often be found that the examiner is not pleased when this condition is reflected upon him; more so, perhaps, when actual verbal intimation is given, than when the question is merely parried, more or less neatly, by an equally vague reply. If a want of precision is seen in an answer, an analysis will often indicate want of precision in the question. One regrets that "not once, or twice, but many times," nearly a whole roomful of candidates in a written examination have risen to ask the meaning of a question: the worried invigilator (who has not set the question), rises and makes a little speech, which may show that he too is at a loss to understand; but he usually contrives to put a gloss over the failings of his colleagues, though the candidates are left as wise after, as before the little address. Perhaps it is the fault of our long-suffering language!!

It is a most striking experience to go over the same ground in a *vivâ* with different examiners; then it is that the contrast between the precise, English-speaking, born examiner and the muddle-headed, self-constructed, made-in-Germany examiner is seen in the most marked manner. But let the reader beware of hinting to the latter of the doings of the former; let him only chew upon it in his own mind. Sometimes it is almost impossible to avoid remembering the epitaph of good old Dr. So-and-so:—

"He was a most excellent Physician,
And a most worthy Gentleman,
But he could NOT examine."

In the examinations that concern us, fortunately the practical side is not entirely neglected—such and such patients, and these and those specimens, are provided for our mutual delectation. A visit or two to a few of the hospitals will show what a variable quantity is the "personal equation" of members of the profession: this is especially seen when the same patient is commented upon by teachers in different schools. The widening influence of different teachers is sought to study this variation of the personal equation, chiefly, if not solely, for examination purposes; the crowds (native nuggets and foreign bodies) that accompany the examiners round their wards attest the truth of this.

The study of the personal equation puts us into a position to grasp the following somewhat Oliver-Wendell-Holmesian propositions. A specimen—living or dead—is exhibited, and the candidate recognises that he has the following possibilities to work upon:—

1. What she,* he, or it really is.
2. What the "examiner" thinks she, he, or it is.
3. What the candidate thinks the "examiner" thinks she, he, or it is.
4. What the candidate thinks she, he, or it is.

* "Place aux Dames."

5. What the "examiner" thinks the candidate thinks she, he, or it is.

6. What she, he, or it tells the candidate or the "examiner" what she, he, or it is considered to be.

Perhaps it may occasionally happen that all these are coincident—we will not endanger ourselves with unripe dogmatic statement.

On the first of the possibilities we need say nothing—it hardly concerns us. It is the third which is the most important, and upon which we will say a few words. A friend of the writer was unfortunate enough to have thoroughly examined a somewhat rare specimen—an old one with a misleading catalogue entry—furthermore, his evil spirit had even led him to dip rather deeply into the subject. When a candidate at a certain examination he found himself placed before the very specimen, whose every chink was so familiar. But he did wrong; he did not act upon the third possibility, he acted upon the first; tempered, it may be, with the fourth. Moreover, he made matters worse by not treating the examiner as a harmless lunatic, and humouring him; he did not grasp the futility of "reasoning" with him.

A *vivâ voce* examination is somewhat like a game of whist, with more or less unknown players; every card that is played arouses inferences, which will regulate and modify the conduct of the game—nay, perhaps it would be more apt to liken it to the American national game—Poker; wherein the expert—be he withal sharp—player observes, and recognises something in every change of facial expression, however fleeting. By knowing something of the personal equation of your opponent, your acumen is not so severely strained.

There remain the candidate's thoughts upon the actual thing; and the examiner's upon the birds of passage flying through the candidate's atmospheric mind. Of course these two propositions may be coincident; the former is to be avoided if possible; the latter depends upon the acumen of the examiner, and to some extent also in his faculty of stimulating the "Precision centre" into activity by arousing his own.

Occasionally it is possible to "lead up to strong hand"—it may be profitable. It is extraordinary how readily some examiners will swim whither they are lured, and take the delicately poised bait; and how, by a little reticence, they can be struck; and how, with a few guarded diffident answers, they can be successfuly landed. This is one of the only opportunities for a little sport that an examination affords: and if done carefully in well-selected cases great benefit may accrue; but it requires deft handling, or the sport may be marred. The gratification of success can, perhaps, best be compared to that felt on landing one's first salmon. But take heed that the fish runs not away with the line, and buries his nose in the mud, or entangles himself amongst little known rocks. All the art of the craftsman will then be required to get him out of the difficulties. Therefore, let the neophyte beware, and let him not think too deeply upon these matters—should they meet his eye, perchance—until he has compassed more than a dozen examinations.

Many interesting topics remain for consideration, but even the Editor—gourmand and gourmet though he is for copy—cries, Hold, Enough! So we must hope for a future opportunity to complete our say of this, and of other aspects of the mutual relations of these eccentric entities.

Δ.

Obituary Notices.

BEAVEN NEAVE RAKE, M.D.

We regret to announce the premature decease of Dr. Beaven Rake, in Trinidad, on August 24th last, of malarial fever, at the early age of 36 years. The following are a few details of his life and career:—

From his childhood up, the late Dr. Beaven Neave Rake manifested the greatest love for books and natural history. The eldest son of the late Thomas Beaven Rake, of Fordingbridge, he was born on April 25th, 1858. In 1872 he entered as a scholar at Oliver's Mount School, Scarborough, whence, after an illustrious career, never returning home for his vacations without prizes for high distinction in his class, he matriculated at the University of London, in June, 1876. After serving a year's apprenticeship with his father, who practised as a surgeon at Fordingbridge, he entered at Guy's Hospital as a Preliminary Scientific Student in October, 1877. During his year at home he searched the surrounding neighbourhood in quest of natural history objects of every description, and neither bird, beast, reptile, nor plant came amiss to him in his universal love of nature. He was passionately fond of the rod and gun. At Guy's Hospital he early evinced an extraordinary capability for perseverance and thoroughness, and passed through all the various examinations and necessary clinical work for his final diploma of Doctor of Medicine, which he obtained in 1882, almost without a drawback, again taking many prizes and winning other distinctions in his progress; he also filled the posts of House-Surgeon, House-Physician and Resident Obstetric Assistant, at Guy's Hospital; and he finally left the Hospital in 1883 to proceed to the post of Superintendent of the Leper Asylum, Trinidad, West Indies, which had been awarded him by the Colonial Office.

Between obtaining his degree and going to the West Indies, he spent a year on the continent, visiting the most celebrated hospitals, and taking courses of cliniques under the most celebrated professors of the medical art in Berlin, Vienna and Paris, and after his return, he for a time, held the post of House-Physician to the Victoria Hospital for Children, Chelsea. He had upheld the honour of the family name at Guy's Hospital (his father having studied there thirty years previously), to such an extent that two younger brothers who followed him, needed no other introduction than this, that they bore his name. Shortly after his arrival in Trinidad, he married, his wife going out to meet him as soon as he had made a home for her, and almost immediately after

that (in June, 1884), he contracted his first attack of that fatal malady, malarial fever, from which he escaped, contrary to the expectations of all the physicians who attended him.

He arose from his sick bed much weakened, and never regained his former strength; but in spite of impaired health, he set to work and made himself master, so far as he could, of that little understood and loathsome disease—Leprosy. His great delight was his Asylum, and he soon became beloved and respected, not only by the patients and "sisters" in the Institution, but also by everybody in the Island.—He was shortly made a Justice of the Peace, and he quickly obtained a world-wide reputation as an authority on Leprosy, owing to his untiring and original researches into the pathology of the disease in which pursuit he spent his leisure time, but his love for natural history never forsook him, and he was constantly sending home to his father curios which he obtained in his expeditions. His vacations, which came round every two years, were always spent in visiting the other centres of Leprosy on the Continent of Europe, amongst other places visiting Norway and Spain for this purpose. When the Leprosy Commission was instituted, under the patronage of the Prince of Wales, in 1890, Dr. Beaven Rake was elected to represent the Royal College of Physicians on the Commission, and was further elected by the five commissioners as their president. In this position he travelled all over India, and the Report of the Leprosy Commission has become a standard work on the subject of that disease. His undermined constitution again suffered from the effects of the unhealthy climate, and it seemed doubtful at one time if his friends would ever see him alive in England again. One of the commissioners died during the term of office. Shortly after his return to England he once more went back to his work in Trinidad, and was destined never to return to his native land. His fate was that which any medical man may wish, namely, to die at the post of duty. The Island had just gone through an epidemic of what seemed to be yellow fever, and his last letter home was full of hope, in that they were free of quarantine, and his future, both literary and professional, never looked so bright. During the epidemic his opinion was asked in consultation by all his fellow doctors, and an old medical friend described him as "one of the most promising men in the colonial service." He had just been elected President of the Trinidad Field Club—by 14 out of 19 votes. "Whom the gods love die young" was his favourite quotation when he heard of a contemporary dropping in harness, and we may truly apply the saying to him, for he leaves behind him a memory beloved and honoured by all who knew him. His deep affection for his parents was always most marked, and his death following exactly two weeks after that of his father bears out the words of the Psalmist, on a similar occasion, "In death they were not divided," for he only had the bare cable-message of his father's decease. He leaves a widow and three sons to mourn his loss, and saddest of all, she was absent from his side at the last, having come to England to start her boys in their educational career.

JOHN FREDERICK McCREA, V.C.

We regret also to announce the death of Surgeon-Major John Frederick McCrea, who won the Victoria Cross during the Basuto war in 1881. He was the son of the late Captain Herbert Taylor McCrea, 43rd Light Infantry, and grandson of the late Major Robert McCrea, 5th Royal Veterans, who served throughout the American War of Independence. He was educated at Elizabeth College and Guy's Hospital. Shortly after obtaining his medical diplomas he volunteered for the Zulu war, and received the appointment of civil surgeon to Her Majesty's forces at the Cape. He served with the Cape Mounted Yeomanry during the following year in the Basuto war, when, for his conspicuous bravery during the severely-contested engagement at Tweefontein on the 14th of January, 1881, the Queen conferred upon him the Victoria Cross. The official description of the deed

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(From a Photograph by Elliott & Fry, Baker Street).

as given in the *London Gazette* of June 28th, 1881, states that "after the enemy had charged the Burghers in the most determined manner, forcing them to retire with a loss of sixteen killed and twenty-one wounded, Surgeon-Major McCrea went out for some distance under a heavy fire, and, with the assistance of Captain Buxton, of the Mafeteng Contingent, conveyed a wounded Burgher named Aircamp to the shelter of a large ant-heap, and having placed him in a position of safety returned to the

ambulance for a stretcher. Whilst on his way thither Surgeon McCrea was severely wounded in the right breast by a bullet, notwithstanding which he continued to perform his duties at the ambulance, and again assisted to bring in several wounded men, continuing afterwards to attend the wounded during the remainder of the day, and scarcely taking time to dress his own wound, which he was obliged to do himself, there being no other medical officer in the field. Had it not been for this gallantry and devotion to his duty on the part of Surgeon McCrea, the sufferings of the wounded would undoubtedly have been much aggravated, and greater loss of life might very probably have ensued. —From the *Daily Graphic*, of August 25th.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

A Suggestion.

DEAR SIR,—May I put before you a suggestion for improving the at present very unsatisfactory arrangements as regards telegrams, parcels and arrival of unexpected visitors?

Many of us, as our work on first joining is confined almost entirely to the Museum block of buildings, or later, because of holding certain appointments, have no occasion to visit the colonnade during the day; and, should we live on the south side of the Hospital, would not of necessity pass along it at any time; whereas, nearly if not all go into the College at some time or another.

Now, I would suggest that the Clubs' Union, with a possible aid from the authorities, should fit up a direct electrical communication between the Front and College porters' lodges. Then, on receipt of a telegram, or a visitor arriving, the College porter could be informed; and he, in the first case, would write up the name on an already suitably prepared telegram-board above letter-box; or, in second case, use the present telephonic means to call the name in smoking-room or dining-hall.

The cost (£12) would not in the long run be excessive. There would, of course, be required some small annual recompense for the porters in order to interest them on our behalf.

I should think this plan might be similary extended to the cloak-room for another £7, and so benefit the younger students.

Might I take this opportunity of remarking that as emergency operations are essentially the ones we, as future general practitioners, are likely to be called on to undertake, would it not be a great advantage to have an electric-bell fitted in quadrangle, that could be rung from College porters' lodge, directly before an operation is about to be performed?

The cost hardly exceeds £1, and this system is at present, I believe, carried out at some other hospitals.—Yours truly,

TELEPHONE.

Whiffs from the Smoking-Room.

AT five o'clock on a November afternoon, with the clock dimly visible through a yellow semi-opaque atmosphere of fog, the smoking-room is not a place to induce very cheerful reflections. At any rate, the Reading Man in his favourite arm-chair, with his head thrown forwards and his hands thrust deep into his trousers-pockets, was gazing at the toes of his boots with an expression of deep dejection. "Liver wrong?" laconically asked the Cynic, his nearest neighbour. "I was thinking," replied the industrious one, "how much of my available energy has been spent in getting in a stock of mere mental lumber of no use or interest whatever, except possibly for exams. I mean such things as exploded theories, or mere guesses masquerading as theories, only set up to be knocked down like a dummy target; and new names for things, either named already or so insignificant as to be unworthy of a name at all. And the worst of it is that the law of the survival of the fittest, does not apply to the struggle of facts for existence in memory. I still remember perfectly well the names of the different segments of the crayfish's limbs, coxopodite, basipodite, and the rest of them, together with many other such babblements meaning nothing, but I have quite forgotten the dose of jalap, which is a solid fact based on experience, and of great importance for the happiness of those of my constipated fellow-creatures who may consult me." "Well," said the Cynic cheerfully, "as to your grievance about the theories, we must have some theories to console ourselves with in the wilderness of facts, and it is a comfort to think how many we have to choose from, all of about an equal degree of probability. Then of course it is rather annoying to have to know three or four synonyms for one thing, but their manufacture provides occupation for the scientists, and they are a great convenience for purposes of mutual definition. Duchenne's disease—tabes dorsalis—locomotor ataxy—peripheral neuro-tabes; you could keep an examiner at bay for an appreciable portion of a quarter of an hour, if he asked what locomotor ataxy is." "That raises another question," said the Reading Man, "I shoudn't mind Duchenne owning the disease, but why should we be expected to know that he is the proprietor? And then Romberg, and Argyll, and Robertson, and Charcot come and seize on separate bits of it whose beauties the original owner had failed to recognise, and fence them off as private property, and the examiners expect us to acknowledge their rights. It is like having to learn Doomsday Book and the feudal system, as a part of the geography of England." "You think," said the Cynic, "that all scientists should efface their personality out of consideration for our limited memories. I know one instance of this sublime self-effacement in a great discoverer, which I have called 'The tale of a Tip.'"

"There was once a man whose energies broke down helplessly against the iron barrier of the College examinations, owing to a deep-seated nervousness which he could never

overcome. He said, 'before I depart to the Antipodes, I will confer a lasting, if nameless, benefit on the profession which has blindly turned me from its doors.' He then invented the celebrated tip, which will save from laceration the posterior tibials of generations yet unborn, and will preserve the name of a certain College examiner long after the 'System' is forgotten. Having thus generally immortalized his bitterest foe, he passed where the Timothies cease from vexing, wrapt in modest anonymity, with the consciousness of duty done for his only reward."

The Reading Man heard this recital in befitting silence, and the Cynic occupied himself with the sporting intelligence in the newly arrived *Evening News*. H.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra amount of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps which have been sterilised by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

R., HADLEY BARNET.—The left kidney is involved in a primary carcinomatous growth. The shape of the cells is generally cubical. There is considerable tendency to necrosis in parts and to the formation of connective tissue in other places. The apex of the left lung is scarred by a patch of healed phthisis. There are numerous masses of secondary growth in the lung.

H., HAMPSTEAD.—The masses passed per rectum consist of mucoid and fibrinous material. In these are found catarrhal cells direct from the intestinal wall. It was imposible to examine for mobile cells.

The specimen of urine sent contained quarter part of albumin per thousand. No casts were recognised. Urea 1·8 per cent. Urobilin present.

A. E. P., LOUGHBOROUGH.—The growth is a spheroidal-celled carcinoma, with considerable surrounding infiltration.

C. E. P., FOLKESTONE.—Tubercle bacilli were present in some quantity.

F. H., STOKE-ON-TRENT.—There is no evidence of malignancy in the section examined.

E. R., CHANCERY LANE.—The casts consist of mucoid material and fibrin. Catarrhal cells are numerous. No masses of malignant cells could be recognised. Is there any continuous hæmorrhage?

F. R. B. B., TUNBRIDGE WELLS.—Tubercle bacilli are present.

S. W. M., SOUTH PELLERTON.—No tubercle bacilli were recognised.

H. L., SALFORD.—The growth is a myeloid sarcoma.

J. M. C., WELLINGTON.—The structure of growth sent is that of an infiltrating squamous-celled epithelioma.

H., CHESHIRE.—(Telegrams sent.)—A. Membrane. No Klebs Söeffler bacilli were recognised in the cultures examined. B. Membrane. Klebs Söeffler bacilli were nnmerous.

A. W., ST. LEONARDS.—The grumous fluid from a heart cyst is deeply coloured by hæmatin. The sediment shows many chelesterin crystals and a few of tyrosin. There are numerous red blood corpuscles present in various stages of degeneration, and masses of large plasma cells resembling the cells found in ovarian cysts. There was nothing found to contra-indicate operation, while no malignant cells were observed in the specimen.

PATHOLOGIST.

Stages.

As a surgeon's clerk I find,
That they underrate my mind,
Though I show my dressers what they make mistakes in.
So my ardour soon expires,
And I seek the smoke-room fires,
Unless we get the very best of "takes-in."

When Medicine is my quest,
And the mysteries of the chest,
To reach a right conclusion oft is trying.
But if not certain quite,
Of a diagnosis right,
Perhaps am aided by the patient kindly dying.

Now my forte will always be
In the art of Surgery,
Of my skill in that there can be no denying.
First I use my eyes with care,
Then my fingers bring to bear,
Last my tongue, for fear the patient may be lying.

At length the longed degree,
Entitles to a fee,
Though a practice takes for most a deal of making.
Still, if knowledge is my friend,
'Twill be all right in the end;
But if not, 'twill be a long-continued "take-in." L. O.

Deaths.

RAKE.—On August 10th, at the Old House, Fordingbridge, Salisbury, Thomas Beaven Rake, M.R.C.S., aged 68.

RAKE.—On August 24th, at Trinidad, Beaven Rake, M.D., Government Medical Officer, aged 36.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* MR. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette.

SEPTEMBER 22, 1894.

Some Introductory Remarks to the Course of Surgical Lectures of 1883.

BY THOMAS BRYANT, F.R.C.S.

THROUGH the kind permission of Mr. Bryant, we are allowed the privilege of publishing some of his original observations, delivered in the Anatomical Theatre as far back as 1883, with the assurance that they will form a more than interesting attraction in this "Students' Number" of the GAZETTE.

The lecturer having expressed his pleasure at again meeting his pupils, extended a hearty greeting to both old and new, as their guide over "the rough, difficult, and possibly dangerous road—the practice of Surgery."

Rough it was, since it was strewn with obstacles, and bounded with a quickset hedge, which would wound if not avoided. *Difficult* it was, if not approached with caution and travelled with determination and good judgment. *Dangerous* it was, both to ourselves and companions, if badly or not understood, and travelled with half knowledge or indifference.

Reading in their pleasant greeting the strong determination to travel the road with their full strength, he hoped this would not be their lot. He, for his part, would endeavour to be a trustworthy guide and cicerone, helping them as far as possible over their difficulties, and hoping to make them, with their own assistance, good and trustworthy surgeons.

By trustworthy surgeons, he meant not merely men with a surgical diploma—however coveted and rightly longed for—but men with enough knowledge to steer clear of difficulties and to guide their patients over dangers; men who practice for the good of those who entrust their healths to them, and who find their own personal interests identical with those of their patients.

To do this they must not only attend lectures and conscientiously *read* text-books; but they must also read the larger book of Nature. They must likewise begin this *early* in their professional career, and learn to educate their senses to understand what is laid out before them in the wards of this Hospital from their *first* entry.

Proceeding next to deal with what surgery is, the lecturer pointed out that in a pathological or scientific point of view there was no distinction to be drawn between medicine and surgery; the separation between the two was entirely arbitrary; the difference (if any) to be detected would be found to be due to anatomical rather than pathological causes. If he could instil into their minds in all its detail—how by natural processes injured skin and soft parts underwent repair, he would consequently do much to help them to know how injured bones, muscles, nerves, arteries, lungs, liver and other viscera were repaired—and if he could show them by what

means the reparative process was helped, and under what circumstances it was interfered with or retarded, he would do much to make them understand the principles upon which the treatment of all external and internal wounds ought to be conducted.

He applied the same remarks to inflammation of any part—the changes being the same in all.

What did surgery embrace?

The treatment of—

(*a*) Injuries generally, not only of the extremities and external parts of the body, but those of the cranial, thoracic and abdominal cavities, with their contents; also of their remote effects.

(*b*) The inoculation of animal poisons, such as syphilis, rabies, etc.

(*c*) Diseases of the bones and joints of the body, and of the soft parts covering them in, as well as of the three great cavities (the cranial, thoracic, and abdominal).

(*d*) Diseases of all the *outlets of the body* and special senses; and last, but not least, surgery embraced the treatment of all diseases that can be relieved by mechanical skill or operation.

Though not in the least wishing to depreciate operative surgery, he would like them to bear in mind that the operative part of the surgeon's duties was neither the most important nor the highest. That consisted in aiding Nature in the cure of diseases or injuries, rather than in the removal of the diseased or injured parts by operative surgery.

It gave the scientific surgeon more satisfaction to save an injured or diseased part with a very slight or without any operation, than to exhibit a limb that had been truncated by amputation, or a joint which had been excised. Let him advise them, then, in all cases to consider, not whether the case could be cured by operation, or was a good one for it, but whether it could not possibly be cured as well *without*.

Operative surgery, known as an *art*, claimed our closest study and even our highest admiration. The practice of surgery, to be successful, must be built upon the science of surgery. Every surgical act—even the smallest—must be based upon a principle or have some end in view.

In lecturing to them on Surgery, he should take them as much into the dead-house as into the wards of the living—for he would impress upon them the important fact that it was through the dead that the phenomena of disease in the living was to be interpreted — that clinical symptoms can only be rightly read through *pathological spectacles*—and that the surgeon's art, if not based on the science of pathology, was nothing but empiricism.

The surgeon *did not cure disease* alone; cures were effected by natural processes working in the physiological laboratory of the living frame. Here the lecturer gave a brief review of the influences the blood and nervous systems bore in relation to the efficient working of nature's processes, illustrating his remarks by references to one who was the subject of a wound, whether healthy or unhealthy. In summing up this point he hoped they clearly understood "that all reparative and curative processes are in their essence natural." He pointed out that these processes are fed and governed by the two *primary forces—the blood* and *nervous systems*—and that these in their turn depend for their integrity upon the efficient working of the *secondary forces*—the *respiratory* and *urinary*, as *blood purifiers*—the *absorbent* and *digestive* systems, as *blood makers*. That when these natural processes fail in fulfilling their mission, they do so because the two primary forces are either themselves at fault or there is some failure in the working of the secondary forces in which their integrity rests, or it may

be because there is some outside influence, septic or otherwise, that interferes with the natural evolution of the reparatory or curative process, or some failure in the directing force.

Passing on to consider the principles that should guide us in the application of operative surgery, Mr. Bryant further added that for the treatment of disease or injury the surgeon should employ his art to help, guide and utilize natural physiological processes, and to remove all such obstacles as may interfere with their steady evolution.

To this end medical treatment, position and mechanical appliances may be required, and when these failed or were insufficient, operative surgery came into requisition.

To understand and know how to treat morbid or diseased processes it was essential, therefore, to be acquainted with the normal or physiological.

The treatment of all "accidental surgery," as well as of wounds, consequently was based on a knowledge of natural repair, a correct appreciation of how it was carried out under the most advantageous circumstances, how it might be interfered with, retarded or arrested, and under what circumstances it was impossible.

In the treatment of *injuries* when repair was impossible or had failed, and in the treatment of *disease* when nature's physiological processes, however skilfully assisted, had proved themselves incompetent to effect a cure, "operative surgery" may be called into requisition; the surgeon's *last resource*, under both circumstances, being made available when all minor means were inapplicable or had proved inefficient.

Operative surgery, then, to be a justifiable proceeding, must be based upon these principles. What John Hunter said ninety years ago is as true now as it was then, viz., "that surgery consists in curing a disease rather than in the removal of it by mechanical means, but so differently do most think upon this subject, that a surgeon who performs most operations, and gives most pain, is commonly thought the best."

Bearing in mind these responsibilities, he wished them to remember that operations were demanded for many purposes. They might be divided into those of *necessity*, including those undertaken to save life directly or indirectly, and those of *expediency*, for other purposes than to save life. Under the first class he would include cases of wounded arteries and hæmorrhage not amenable to other treatment, of strangulated hernia, foreign bodies in the larynx, retention of urine, and acute intestinal obstruction, in which operation would be undertaken to save life *directly*; aneurism, tumours, bad compound fractures, irretrievably disorganised joints, removal of dead bone, extraction of a calculus from the bladder, and tapping for fluid in chest or in ovarian disease, in which operation would be undertaken to save life *indirectly*. Under operations of *expediency* he included disfigurements, deformities, simple tumours, etc. Having decided to operate, the next question had reference to *the best and most successful form of operation;* the *best time* for its performance, and the *conditions* under which a good result might probably be expected. In operations of *expediency* the patient should have a full understanding of the risk to life, the surgeon a full sense of his responsibility. He would have them comprehend fully that there was no operation, however trivial, which was not attended with some risk. Let the patient know the probabilities of success or failure and what liabilities he or she incurred. Following in the same strain Mr. Bryant proceeded to warn them on no account to let the wish of the patient to be relieved of a real or imaginary trouble, tempt them to undertake an operation, however trivial, against their judgment.

In selecting one of the many alternatives in operating, the surgeon must be guided by a

principle, and have clearly before him the object in view. Here the lecturer gave some examples, as in operation for joint mischief, the question of erasion or resection would come into consideration in preference to amputation, and the expediency of free incisions rather than excision. Should *amputation* be decided upon, the diseased or injured extremity was to be removed as close above the seat of mischief or disease as was compatible with safety—since the principle of the *least sacrifice of parts* ought to be invariably followed, and no more of the body be taken away than was called for by the necessities of the case. No preference to the surgery of the foot for a Hey's amputation, a Chopart's, a Pirogoff's, or a Syme's was to have any weight with them. They were to learn to know that as a duty they were to remove from the body only what nature unassisted could not cast off, and what if left would interfere with life or life's usefulness; finally, they were to do this with the least risk to life, with the least sacrifice of parts, and with the least local disturbance. Never let them be tempted to perform an operation from the pleasure it might afford them, the benefit its performance might do them in the eyes of their neighbours, or the whip it might perhaps give them over a brother, and possibly a rival, practitioner.

Look upon every case from the patient's point of view, and from no other. Do from necessity what the necessities of the case require, and do what has to be done in the simplest and safest way.

In conclusion, Mr. Bryant bade his hearers ever to remember that patients were not subjects but living human beings, with all their feelings, anxieties, responsibilities and hopes; and that the great Christian principle of doing unto others what we would they should do unto us, was as applicable in the practice of surgery as it was in the performance of the general duties of life.

The Foundation of Guy's Hospital.

GUY'S HOSPITAL was founded by Thomas Guy, a bookseller and publisher in the city of London, in 1724. In the year following it was incorporated by Act of Parliament. In Guy's will, which occupied fifty-five pages, and was published in 1725, the text of the foundation of the Hospital is set forth. All the residuary estate was left to the Governors of St. Thomas's Hospital on trust to finish the new hospital, and such other buildings as might be necessary. Beds were to be provided to "receive and entertain therein four hundred poor persons, or upwards, labouring under *any distempers, infirmities or disorders thought capable of relief by physic or surgery;* but who by reason of the small hopes there may be of their cure, or the length of time which for that purpose may be required or thought necessary, are or may be adjudged or called incurable, and as such, not proper objects to be received into or continued in the present Hospital of St. Thomas, or other hospitals in and by which no provision has been made for distempers deemed or called incurable: of whom my mind is, that they receive and entertain lunatics, adjudged or called, as aforesaid, incurable, not exceeding twenty in number at one time." Further, the will declared that if the executors and trustees did not think fit, "on any account whatsoever, to keep all or the great part of the beds filled with sick persons deemed incurable, it should be lawful for them to cause any number of the said beds or wards to be filled and made use of, in like manner and with like patients, as the beds in the hospital of St. Thomas are ordinarily used."—(From "Biographical History of Guy's Hospital," by kind permission of Dr. Wilks).

The original building formed two squares, now known as the "surgical buildings." In 1739, on an additional piece of land, were built the treasurer's house, the counting house, with the governors' court-room, the medical superintendent's and the old dressers' block on the eastern side, the nurses' block, the chapel, and the chaplain's and apothecary's houses extending to the street on the western side. The building in its early state contained twelve wards and four hundred and thirty-five beds.

The "Lunatic House," converted into the "Clinical Wards" in 1860, was completed in 1774. It furnished accommodation for twenty confirmed lunatics. Nearly a hundred years later the reception of lunatics into a general hospital was discontinued, and the two new wards, "John" and "Miriam," were opened on May 1st, 1860. A high wall which hitherto had separated the airing grounds of the lunatics and general patients respectively, was then demolished, the two grounds forming, with some fresh property acquired, an extensive area now known as the "Park." In one corner of this was erected, in 1861, an alcove obtained from old London Bridge on its removal in 1831. The chapel was rebuilt and redecorated in 1858. In 1867 a new operating theatre was constructed on the north side of "Guy's

House" at considerable difficulty and expense. About 1870 "Esther Ward" or "Chapel Ward" was removed. Its place is now occupied by the corridor between Job and Lydia and the rooms for the use of the night sister, out-patients' sister, and some of the nurses.

Hunt's House, the most important addition to the buildings of Guy's Hospital, was commenced about 1850; the south wing completed in 1853, the north as late as 1871. The block known as the Medical Buildings consists of five separate floors opening directly on to the main staircase. On the ground floor are the Out-patient Departments, the Dispensary, and Medical School Office in the south wing; the Ophthalmic wards and the Anatomical Museum in the north wing. On the first floor are Philip and Mary wards; on the second floor Stephen and old Mary wards—now used for examinations, etc.; on the third floor is Bright ward, where private patients are located, and Addison, an emergency ward; on the fourth floor are the nurses' dormitories.

THE MEDICAL SCHOOL.

The School of Medicine and Surgery attached to Guy's Hospital may be considered to date its formal commencement from about the year 1769, when a resolution was approved by the Governors to the effect that "All such persons as shall be chosen Surgeons to this Hospital shall occasionally give Lectures on Surgery to the pupils that shall be entered at this Hospital." A short time before this, however, Dr. Saunders, who had previously lectured on Medicine at his house in Covent Garden, on being appointed Physician to the Hospital, began delivering his Lectures here. He may therefore be regarded as the founder of the Medical School.

In the year 1768 it was resolved "that the barrier between this Hospital and St. Thomas's be taken down, and that the pupils of St. Thomas's have free leave to see not only the operations, but also all the other practice of this Hospital." Corresponding advantages were afforded to the students of this Hospital by the Governors of St. Thomas's. In the year 1825 this union was dissolved, and by a resolution of the Governors of Guy's Hospital the Treasurer was requested and authorised "to make such arrangements as he may find necessary to provide for and place the Surgical School of this Hospital in all its departments on the most respectable and efficient footing."

The School Buildings have undergone striking changes during the past few years. A detailed account of them will be found on pp. 27, 28 and 29 of the Green Book. The most recent addition—that of the new Petersham Buildings—contains the Dental Buildings, the Chemical Laboratory, the Physical Laboratory and Theatre, the Laboratory for Public Health, and the Laboratory of Bacteriology.

For the Museum of Pathological Anatomy the new catalogue, but lately published, by Dr. Shaw and Dr. Perry, will be found of extreme value. It may be obtained at the Library.

How to begin Work.

ANATOMY AND THE DISSECTING-ROOM.

THE first working day spent at Guy's Hospital is always a memorable event. There is a feeling of strangeness, which is quite natural. We are but vaguely conscious of what is to be done, and blissfully indifferent how to set about it. The very names of the subjects we have been told to learn convey no meaning, and the School buildings, with their various class-rooms and theatres, are an unexplored country through which we travel as in a maze.

For the help of the new men, it is proposed to give such instructions as they may need in beginning the work of their first Winter Session at Guy's. It will be assumed that they have already decided what the general course of their study is to be, that is briefly, whether they are going in for the Preliminary Scientific Examination of the London University or not. Information on these matters is readily obtained at the Medical School Office, and any student who is not clear in his mind as to the examination he has to prepare for should read carefully page 64 in the Green Book.

After the first few days men soon become familiar with the work and learn from one another. But at first they have made no acquaintances and all around them are strangers alike.

Monday, October 1st.—There is no actual work done on this day, but students arriving at the Hospital in time should purchase the books and instruments required for the next day. These are enumerated below. If "a part" (the name given to the portion of work allotted to each student in the dissecting-room) has not been paid for, that must be done at once, so that there is no unnecessary delay in beginning dissection. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground-plan at the front of the Green Book will show them at a glance, and serve as a very efficient guide. During the evening there will be a dinner in the College Hall (admission by ticket, which may be obtained of the Club Steward in the Dining Hall); and this will be followed by a meeting of the Physical Society of Guy's Hospital in the Anatomical Theatre, to which all new men are specially invited. The programme of this meeting will be found in another column.

Tuesday, October 2nd.—At 9 o'clock in the morning the start is made, and we get our first introduction to the duties of hospital life at a lecture in the Anatomical Theatre, which every new student is expected to attend. After that proceed to the dissecting-room, find out your "part" for dissection, and procure the requisites for work if these have not been already obtained.

TO FIND A "PART."

Look down the lists of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known

and report the fact to one of the demonstrators present, who may be recognised by his white coat. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with the cloth.

THE REQUISITES FOR DISSECTION.

The following articles are essential and must be purchased at once:—

a. Case of instruments. This should contain at least four knives, forceps, scissors, hooks, needle and blowpipe. Price 15s. to 18s., at Messrs. Down Bros., of St. Thomas's Street; or at Messrs. Hills & Co., of Newcomen Street.

b. Books. These are obtainable at Grattan's in the Borough (No. 16). It will be necessary to have *Ellis's Demonstrations of Anatomy* (price 9s. 6d.) for use in the dissecting-room, which shows how to proceed and what is met with in the course of dissection; as well as *Gray's Anatomy* (price 27s.), which must be used in studying the bones and for reading at home. Note-books and pencils will be wanted later.

c. An apron and sleeves to keep one's self clean. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose, the key of which is obtained by making a deposit of 5s. at the Medical School Office. During the day hats and coats are kept at a special cloak-room free of charge.

HOW TO DISSECT.

The instructions on this point given in the text-books are by no means clear to one who has never done any dissecting in his life, and does not know the meaning of half the scientific words in which the directions are given. He finds quite a new language in use, and no translation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical descriptions depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful art of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The object of dissection is to enable the student to see and handle the different structures that he reads about in his books. It is most decidedly NOT the object of dissection to lay bare the bone in the middle of the "part" in the shortest possible time. That is butchery, not dissection. Remember then these few points:—

1. Cut through the skin along the lines given in the books.

2. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

3. Take away the fat carefully without damaging the flesh or muscle underneath it.

4. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks; then with the point of the knife clear away everything covering the muscle by working with its grain or fibre, *not* against it.

Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's worktime. Cover the "part" up with a cloth before leaving it for the night.

OSTEOLOGY.

Usually considered a very dry subject; hence commonly studied in a stuffy museum after a heavy lunch with—the usual result. Like other branches of anatomy, it must be learnt practically, by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the hospital, it is very important that each student should possess them. Half-sets of osteology, that is, the bones of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second-hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the Second Conjoint Examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is well to have the guidance of a fellow-student who is familiar with them. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked, and dirtier ones. The preparation which makes them white, does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly; as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, hence cannot be articulated. The value of such a skull is very small.

T.

PHYSIOLOGY.

During the first Winter Session, read Huxley's *Elementary Lessons in Physiology*. Those who already know some Anatomy or Biology may replace this by Starling's *Physiology*.

In the first Summer Session, attend the Practical Histology class, and read the subject in Schäfer's *Essentials of Histology*. For this class students must supply themselves with a compound microscope and mounting materials. The microscope must be approved of by the Demonstrators. It is no use bringing up an antique

instrument that may have formed part of the furniture of the Ark, nor can a proper instrument be bought at the stores or the family grocers. Those who can afford it should bring a Zeiss' microscope (about £10). Swift sells a very reliable instrument for about £6. The microscope should have two objectives, ⅔-inch and ⅙-inch. The demonstrators will be very glad to advise any student with regard to the choice of a suitable microscope. The mounting materials will cost about 10s., and can be procured from Stanley's, on the London Bridge Railway Approach. A list of the requisite apparatus may be had at the School Office. Those who intend taking the London M.B., or the F.R.C.S., should also read the Histological part of Quain's *Anatomy*. In the second Winter Session the Physiology lectures must be attended. At the same time the subject must be attacked in earnest by reading, and the best book is probably Waller's *Human Physiology*. Those who find this too difficult, may read instead Yeo's *Manual of Physiology*, which is extremely clearly written, and is, perhaps, the easiest of all the reliable text-books.

During the latter half of this Session, students must attend the practical classes held once a week in Chemical Physiology. It would be useful, in connection with these classes, to study Halliburton's *Essentials of Chemical Physiology*. During this Session most men will also attend the Revision Classes, held in preparation for the Examination of the Conjoint Board.

For London University men the course must be somewhat modified. They should read Waller, Bunge's *Physiological Chemistry*, and certain parts of Halliburton's larger work. Histology and Embryology should be read in Quain's *Anatomy*.

During the whole of the second Winter Session they should attend the class in "Advanced Practical Physiology," and in the second summer the revision classes held in preparation for the Intermediate M.B. Those who intend trying for Honours should supplement this course of reading with some of the more important papers which have appeared in the *Journal of Physiology*, and should pay especial attention to Histology and Practical Histology. Gamgee's *Physiological Chemistry* may be also strongly recommended to those interested in the subject. Candidates for the F.R.C.S. should remember that this is a severe, but not an advanced Examination. They may read the same books as are recommended for the ordinary men, but they must know their subject, and especially their Histology and Embryology very accurately. It is advisable for them to attend the advanced classes in Practical Physiology.

S.

BIOLOGY.

The course of lectures and demonstrations for the requirements of students preparing for the First Conjoint Examination, is given in the Physical Lecture Theatre, in the Dental School Buildings, at 10 on Mondays and at 9 on Fridays. The practical class will be held immediately after the lecture, and the new student is reminded that it is most important for him to attend both lecture and practical class from the *very first*, to obtain the knowledge in Biology requisite for the Conjoint Examination. The very closest attention to his work, more especially *in the practical part*, is necessary if the pupil would become familiar with a subject which, seemingly not of much value to him now, will be of no inconsiderable assistance in later work, particularly in the domain of Morbid Histology and Bacteriology.

The first lecture will be given in the Physical Lecture Theatre on *Friday, October 15th, at 9 a.m.* For the practical class the requisites, of which a complete list is given below, must be obtained *beforehand*. We recommend new men, with reference to the purchase of a microscope—perhaps the most important consideration in entering these classes—that it should be deferred until one of the demonstrators has been consulted. We may state that microscopes are not absolutely necessary for the early classes, so that the purchase of one may be safely withheld until full instructions have been received from the demonstrators. Work will be commenced upon the "Dog Fish."

The special course of lectures and demonstrations devoted to the Preliminary Scientific Examination of London are held on Wednesdays and Fridays at 10.30 (*not* at 10, as announced in the Green Book). The first lecture will be given by Mr. Beddard on Wednesday, October 3rd, in the Biological Class Room No. IV., on the first floor of the Pathological Museum block of buildings. "Pre. Sci." men will require the set of requisites that are notified below.

With regard to this list, we have already referred to the "microscope." In purchasing "a dissecting case," students must understand that an ordinary (human) anatomical set is *all* that is required. The special "biological" set are by no means necessary for the elementary work required at Guy's, and are therefore a needless expense. The other accessories are to be obtained of Messrs. Stanley, Railway Approach, price 20s.

Requisites for the Practical Biology Class.

Every student attending these classes must provide himself with a microscope with a double nose-piece, and indicator fitted in eye-piece. Zeiss's stand, with objectives A and D, and low eye-piece, price about seven guineas, is very strongly recommended. To be obtained of R. Kanthack, 21, Golden Square, Regent Street, W., or Messrs. Baker, High Holborn. English patterns may be obtained of Messrs. Beck, Ross or Swift. A stoppered bottle (with glass rod) containing Canada Balsam, dissolved in xylol; a stoppered bottle containing xylol; three small white saucers with flat bottoms; three watch-glasses ground on convex surface; two section-lifters; three needles in handles; a pair of microscope scissors (curved on the flat); ½-oz. No. 1 ¾-inch cover glasses; a gross of glass slides; a packet of labels; a note-book; H.B. black pencil; red and blue pencil; a small piece of soft silk; fine curved forceps; a "Seeker"; an anatomical dissecting case; a razor for cutting sections.

C.

CHEMISTRY AND PHYSICS.

Science is essentially experimental and practical, and it is impossible to get accurate ideas on any scientific subject without constant and attentive work in the laboratory. The futility of attempting to study anatomy without dissecting bodies, or disease without seeing patients, is obvious; but some do not seem to realize that to attempt to study chemistry and physics without making a practical acquaintance with the various forms and transformations of matter and energy is equally futile.

University students at Guy's will find lectures and classes adapted to their requirements in these subjects: Oxford, Cambridge and Durham men should consult the demonstrators; the various classes for London men, who are expected to devote a large amount of time to chemistry and physics, are set forth below.

For the Preliminary Scientific (M.B.) Examination the lectures on Chemistry are the same as for the Conjoint Examination (see below); but the text-books are Thorpe's *Inorganic Chemistry* (Collins, 2 vols.), and Tilden's *Chemical Philosophy* (Longmans). The practical work extends over the whole year (winter, Mr. Wade, Monday, Tuesday and Thursday, 2 to 4; summer, Messrs. Groves, Wade and Hopkins, Monday, Wednesday and Friday, 10 to 1). Written instructions are provided. Revision classes, at which test examination papers are set, are held during the session before each examination. Experimental lectures on Physics are delivered by Professor Reinold weekly throughout the year (winter, Monday at 12; summer, Friday at 2); the text book is Deschanel's *Physics* (Blackie), best bought in four parts. The practical work also extends over the whole year (Professor Reinold and Mr. Wade, Wednesday and Friday at 2), and written instructions are provided. More details as to the Preliminary Scientific classes will be found on the notice-board in the Chemical Laboratory.

For the Intermediate Examination in Medicine, experimental lectures on Organic Chemistry are given weekly twice a year by Messrs. Groves (May–July) and Wade (October–December). A thorough elementary knowledge of the subject is required, and to obtain this, practical work is indispensable. Six months in the laboratory is the minimum, but students are advised to avoid hurry and to extend their course over nine months during the two years they have at their disposal. The practical classes are held from October to December (Mr. Wade, Monday, Tuesday and Thursday, 2 to 4), and from May to July (Messrs. Groves and Wade, Monday, Wednesday and Friday, 10 to 1). Students who have just passed the Preliminary Scientific Examination are advised, therefore, to begin next May. Candidates for Honours require a much more extensive knowledge of the subject, and cannot begin too soon. Further details as to revision classes, etc., will be found on the notice-board in the Chemical Laboratory.

For the M.B. Examination a knowledge of Practical Toxicology is required. This may be obtained at classes conducted by Dr. Stevenson and Mr. Hopkins, commencing in February and May.

Students who intend to work for the Conjoint Diploma should pass the examination in Chemistry and Physics at the end of their first year. For this purpose they must attend a six months' course of lectures on Chemistry (Dr. Stevenson, October–December, Tuesday, Thursday and Saturday, at 11, and Mr. Groves, May–July, Tuesday, Thursday and Saturday, at 10.30), and a three months' course of lectures on Physics (Professor Reinold, May–July, Friday, at 2). At the same time they should read their text-books (Roscoe's *Elementary Chemistry* and Balfour Stewart's *Elementary Physics*). In the summer they must work through a three months' course of Practical Chemistry (Messrs. Groves, Wade and Hopkins, Monday, Wednesday and Friday, 10 to 1). Revision classes, at which test examination papers are set, are held for five weeks before the July examination. Students now entering, who do not wish to fail next July, are most strongly urged not to leave their reading until the summer, but to start as soon as the lectures commence, and keep pace with them. Referred candidates must in future be signed up for a further course of three months' work before re-examination, and for this purpose special classes will, if necessary, be held before the January and April examinations, but admission to these will only be granted under certain conditions. The attention of students is drawn to the New Regulations on page 60 of the Green Book.

Dental students should attend the lectures as above, and work at Practical Chemistry from January to March (Mr. Wade, Tuesday and Thursday, 2 to 4).

J. W.

MEDICINE.

Medicine lectures are held on Mondays, Wednesdays, and Fridays, at 3 p.m., in the Anatomical Theatre, throughout the Winter Session, by Dr. Pye-Smith and Dr. Taylor. The introductory lecture will be given by Dr. Pye-Smith on Tuesday, October 2nd, who will then proceed to discuss "Fever, Contagion, and Specific Diseases."

A Clinical lecture is delivered every Saturday, at 1.15 p.m., in the Chemical Theatre, the first of which will probably be given by Dr. Taylor on Saturday, October 6th. These lectures are held at 1.15, so as to enable footballers to attend, and they finish in time for them to catch the 2.35 train to Honor Oak Park.

In addition to the above course, Dr. Shaw holds Revision Classes for six weeks before the Final Conjoint Examinations in January, April and July, for the benefit of students desirous of presenting themselves for the Final Examination in Medicine.

THE MEDICAL WARDS.

Clinical Instruction in Medicine is given in the medical wards to the medical ward clerks and other students who choose to be present, by the Physicians, who visit their cases from 2 to 5 p.m., and by the Medical Registrar in the mornings from 10 a.m. to 1 p.m. There are two male wards, Philip and Stephen, each containing forty beds, and one female ward, Mary, containing fifty beds and six cots. The latter is divided into four divisions, each Physician taking one division. Dr. Pye-Smith and Dr. Goodhart divide the beds in Philip ward between them, and Dr. Taylor and Dr. Hale White, those in Stephen ward. On Mondays and Thursdays the wards are visited in the afternoon by all the Physicians; on Tuesdays by Dr. Goodhart and Dr. Hale White; on Fridays by Dr. Taylor, Dr. Goodhart and Dr. Hale White, and on Saturdays by Dr. Pye-Smith. The Medical Registrar sees new cases in all the wards on Monday and Thursday mornings; on Tuesday, Dr. Taylor's cases; on Wednesday, Dr. Goodhart's; on Friday, Dr. Pye-Smith's, and on Saturday, Dr. Hale White's. Thirty-six medical ward clerks are appointed every three months, and are eligible for reappointment at the end of this time for a further period of three months, the extension being given to those who have shown the most care and diligence in the discharge of their duties.

1. *Case taking.*—Reports are made by the medical ward clerks on all the cases admitted to the wards, under the supervision of the Medical Registrar, who instructs the clerks in the mornings, in the method of case-taking, and the physical examination of patients. Special report sheets are kept for this purpose in the wards; on the front page, spaces for the name, age, occupation, address of patient, ward, number of bed, physician, date and references to former admissions, if any, must be filled in, the report itself must be then started on the next page, by recording the most prominent symptoms for which the patient was admitted, *e.g.*: "The patient was admitted for hæmoptysis, ascites, vomiting," or as the case may be. If the patient has been an in-patient before, the old report must be looked up in the Registrar's room, which is in the new building, on the right hand side of the stairs leading to the medical wards, the key of this room being hung up behind the door of the Eye wards opposite. Since the year 1888, an index of all the patients' names has been made a separate volume for each year, and they will be found in this room on the table. Having found the patient's name, a letter and a number will be found after it, the former is the initial letter of the Physician, the latter the number of the report in that Physician's volume of reports for that year, *e.g.*: if a patient had been in the medical wards in 1890, and the name is found in the index with P.S. 100, after it, it would mean that he was under Dr. Pye-Smith, and his report would be number 100 in Dr. Pye-Smith's volume of reports for 1890. The clinical reports for the year are all bound together, and the letter C refers to the clinical volume.

If the patient has been in the Hospital before, during the current year, his report can be obtained by applying to the Medical Registrar. If he comes under the same physician the report must be continued; if under a different physician, an extract must be made and a new report commenced.

Before the year 1888 an index of names will be found at the commencement of each volume.

The old report having been found, an extract must be made, and the diagnosis then arrived at inserted in the new report. The condition of the patient since his last discharge from the Hospital must then be noted; then the commencement of the present illness, with the symptoms and the date (not the name of the day only) of their onset, and the treatment before admission. Supposing there has been no previous admission, after stating the leading symptoms for which the patient was admitted, a description of his previous manner of life, occupation, travels, etc., must be noted, then his family history, especially in diseases of the nervous system, gout, rheumatism, phthisis, etc., then a history of previous illnesses, with dates, and then of his present illness, as above described, and lastly, the condition on admission; this last mentioned is the most important, and should be done as soon as possible. If the Clerk has not seen the case on admission the necessary details may be obtained from the House-Physician. The condition on admission should be commenced by noting the pulse and respiration rate, and the temperature and general appearance of the patient; this should be followed by a description of the system primarily affected, then the system most likely to be affected by complications, *e.g.*, in a case of acute rheumatism first describe the articular, then the circulatory, respiratory, cutaneous, alimentary and nervous systems. When describing physical signs the results of the examination should be arranged as far as possible under the headings Inspection, Palpation, Percussion and Auscultation, and it should always be remembered to use the eyes before the hands and the hands before the stethoscope. In acute cases a daily record of the physical signs, symptoms, and the general condition of the patient must be kept. In renal cases a daily examination of the urine must be made and the result noted on charts provided for this purpose. In all cases the treatment written on the bed letters must be copied into the reports. Observations made by the Physicians on their rounds should be reported, great care being taken not to misinterpret them.

When the patient leaves the Hospital a description of his condition on the day of discharge must be noted, and the report concluded with a short epitome of the leading features of the case. If the patient dies, an abstract of the post-mortem report, which can be obtained in the post-mortem room, must be inserted. When the report is completed, it must be taken to the Medical Registrar's room.

2. *Temperatures.*—The temperature of the patients must be taken and noted every morning by their

respective clerks. Evening temperatures are taken by the clerks in turn; the dates for this duty will be found on the notice-board in the central hall of Mary ward. The temperatures to be taken will be put on a card hanging on the wall in each division.

3. *Classes.* On Thursdays, classes are held for all the medical ward clerks at 12 o'clock, in the surgical class room, on the application of anatomy to medicine, the methods of medical diagnosis, and the explanation and interpretation of physical signs. On Mondays, at 12.15, classes are held in the clinical laboratory for Dr. Goodhart's and Dr. Hale White's clerks; and on Tuesdays at 2 o'clock for Dr. Taylor's and Dr. Pye-Smith's clerks, when practical demonstrations on the examination of urine, blood, sputum, etc., and on the use of the various instruments required for clinical investigations are given by the Medical Registrar.

4. *Beds.* The arrangement of beds will be found on the notice-board in Mary ward.

5. *The Clinical Laboratory* (door opposite the lift in the new building), is open to medical ward clerks between 10 and 1, for any special clinical investigation and for the examination of sputum. The key can be obtained from the Medical Registrar, to whom also application for any special apparatus or reagents must be made.

6. *Medical Instruments.* Instruments for clinical investigations – hæmocytometer, hæmoglobinometer, perimeter, spectroscope—are under the charge of the Medical Registrar, and can be obtained from him on application.

A few practical hints:—Medical Ward Clerks should, first of all, make themselves familiar with the normal physical signs, *e.g.*, the normal shape of the chest, the normal vesicular murmur, the normal cardiac sounds, etc., and then with the physical signs of disease, their mode of production and their special import. It will be found useful, first of all, to read a book on physical diagnosis, such as Fenwick's *Medical Diagnosis*, or Gibson and Russel's *Outlines of Physical Diagnosis*.

As a text-book Taylor's *Medicine* cannot be improved upon. Do not start at the first page and read straight through; read up and endeavour to understand your own cases. When this has been done, use your colleague's cases in the same manner. Do not be rough with your patients; percuss and palpate gently. Do not sit up a patient suffering from Typhoid to examine his back. Do not percuss the chest of a patient suffering from Hæmoptysis. Do not test the knee-jerks of a patient suffering from Acute Rheumatism; and if you sit on his bed, look before you sit. Do not discuss with your colleagues in the patient's hearing the prognosis of the case if it be serious, or the probable post-mortem appearances of his organs. If possible, imagine yourself in your patient's position, and then you will treat him with consideration.

M. R.

MORBID HISTOLOGY.

These classes are held by Dr. Newton Pitt, in Classroom No. II, on Thursdays and Saturdays at 9.30 a.m., commencing on Saturday, October 6th. Sections are given out ready to be mounted, illustrating the more important lesions of the liver, kidneys, spleen, adrenal bodies, alimentary canal, lungs, pleuræ, brain, and spinal cord. Three or four specimens, together with a short written description, are given out each morning. These are examined, and the demonstrators point out the important features in each section. Each student must make a sketch or diagram indicating the changes illustrated by each section, and the sizes of the various elements are measured by the eye-piece micrometer. It is important that students should all be provided with the micrometer before the first class, in order that the values of the divisions may be determined for them then.

Each student attending these classes must be provided before the first meeting with a text-book on *Pathology*, by Dr. Sims Woodhead or by Dr. Green; a microscope fitted with a double nose-piece, and two objectives, viz., an inch, and a higher power, either a quarter or a sixth. Also the following accessories, which may be procured from Messrs. Stanley: An eye-piece micrometer, cost half-a-crown. This must be fixed in so that the lines are accurately in focus when an object in the field is clearly seen; the values of the divisions will be determined at the first class. A glass capped bottle with glass rod, filled with Canada Balsam dissolved in xylol; a wide stoppered bottle, with clearing fluid, either oil of cloves or a mixture of carbolic acid and turpentine; a capped bottle of Farrant's solution; two small saucers with flat bottoms; a watch glass; half an ounce of square cover glasses, ⅞-inch; a gross of glass slides; a packet of small filter papers; two lifters; two needles in handles; a box to hold twelve dozen slides horizontally; a note-book; H.B. black pencil and a red pencil; an old linen handkerchief. Dr. Pitt will be glad to advise those students who require to buy a microscope. P.

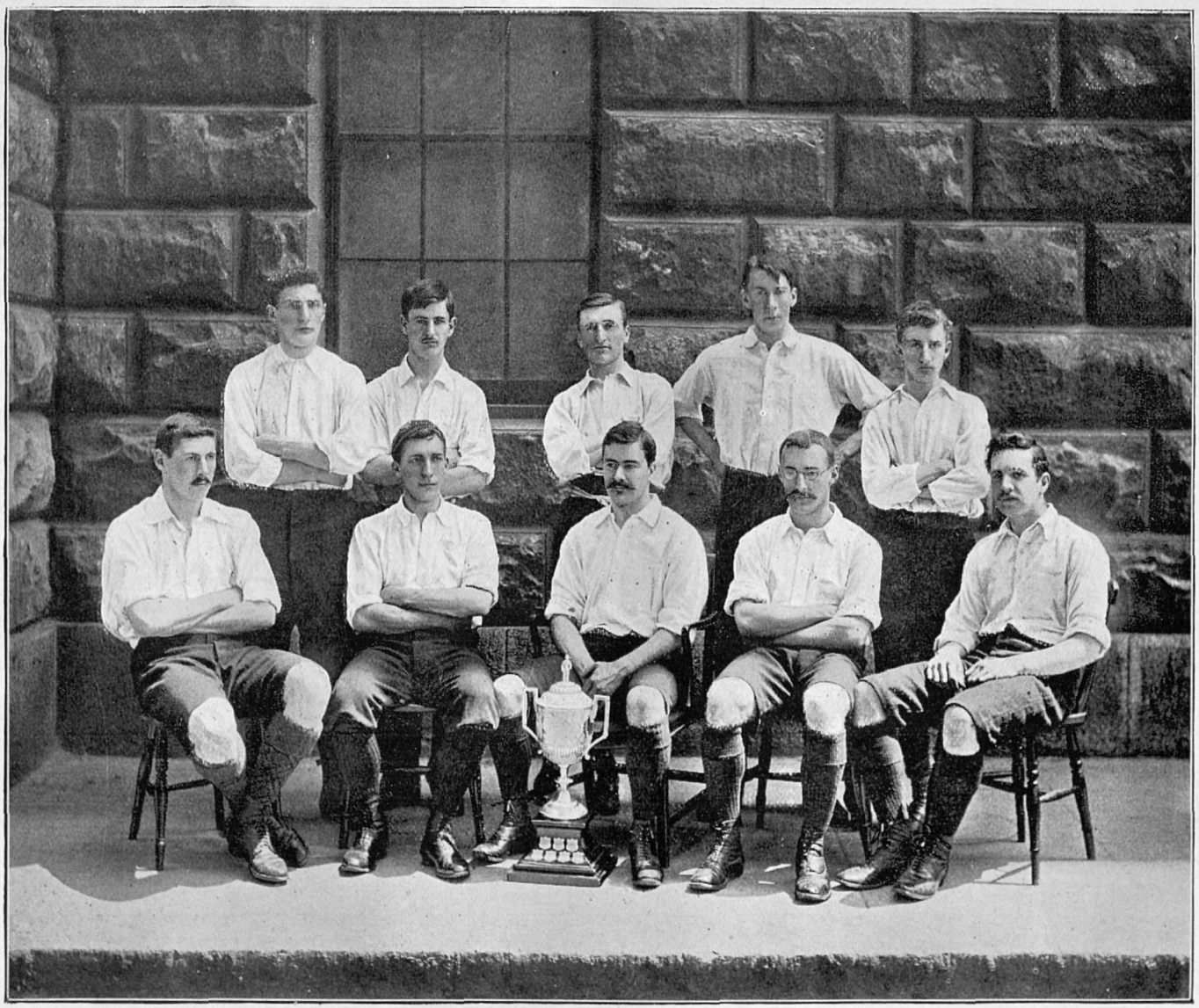
SURGERY.

Lectures are held three times a week, on Tuesdays, Thursdays and Fridays, at 1.30 p.m., in the Anatomical Theatre, by Mr. Howse or Mr. Davies-Colley. Mr. Howse for the first part will lecture on "General Surgery," commencing on Tuesday, October 2nd. Clinical lectures are given on Wednesdays, at 1.30, in the Anatomical Theatre, by the Surgeons. The first will probably be given by Mr. Davies-Colley, on Wednesday, October 3rd.

Mr. Lane holds classes in "Practical Surgery" four times a week in Classroom No. I. These classes are open to men in their third year, and must be attended to fulfil the requirements of the Conjoint Examining Board. A list will be posted in the colonnade, giving the names of those who are not yet "signed up," with the days on which they are expected to attend.

Mr. Dunn, six weeks before the Final Conjoint Examinations in January, April and July will hold "Revision

Guy's Hospital Association Football Club.—Season 1893-94.



A. B. CARTER. L. HUMPHRY. C. E. HIBBARD. F. E. WALKER. A. E. B. CROSBY.
R. B. STAMFORD. R. T. FITZ-HUGH. H. HEWETSON *(Capt)*. F. J. LIDDERDALE. N. LAVERS.

[*Absent* A. M. DANIEL. N. C. COOPER.

From a Photo by] WINNERS OF UNITED HOSPITALS' CHALLENGE CUP [J. RUSSELL & SONS, Wimbledon.

GUY'S HOSPITAL LIBRARY

Classes," upon which attendance is voluntary. Only those desiring to present themselves for examination are expected to attend.

Mr. Symonds will hold a course of "Operative Surgery" for final M.B. and Fellowship men in October, of which further notice will be given. The course for the requirements of the Conjoint Board will be held in January, 1895. Names of students desirous of attending the M.B. course should be left at the medical office *before* the end of September. Mr. Higgens will lecture on "Ophthalmic Surgery," on Wednesday, at 3 p.m., in the Ophthalmic Operating Theatre. These lectures must be attended after passing the Second Conjoint Examination before admission to the Final Conjoint.

THE SURGICAL WARDS.

Much that has been said of the Medical Wards applies equally well to the Surgical Wards. There is, however, a great difference; for, whereas ward clerks and others may sit with impunity upon the beds in the former, from the very necessity of having to examine one's patients carefully and *comfortably*, such an occurrence becomes a crime in the surgical wards, except under very exceptional circumstances. Then, too, ward clerks in the medical wards are more on their own responsibility than in the surgical. Here they are more or less at the beck and call of their house-surgeons and dressers. From personal experience we can assure the much-despised, albeit useful, if not ornamental, surgical ward clerk that though he has to write reports, attend operations, carry screens, lift and carry bedridden patients, etc., and naturally perform any small office for the sisters, his lot, far from being an unhappy one, may be made "a jolly good time," as he will doubtless soon learn for himself, as he gets to know his "firm." A word in season to the dressers, too—though it is their good fortune to be ahead of their ward clerks and assistant-surgeons' dressers, let them remember that from the very position they occupy much consideration for others is expected from them. As a rule, there is no friction in a good firm; but occasionally there is a rift within the lute, and here the dresser's tact and good temper may be of the greatest service. One perhaps need hardly mention the necessity of absolute cleanliness and asepsis in these days, though an erstwhile "smart ward clerk" was but a short time since observed, when full dresser, to be performing his duties in a "shocking old and dirty habit." When remonstrated with by his horror-stricken house-surgeon, he casually remarked that it was of no consequence to *him*, as the coat was "only an old one," and so would not suffer from contact with dirty dressings. Ye gods! What availeth it, if our only poet sing his "Song of sepsis" when surgeons' dressers such thoughtless things do do?

The surgical wards are visited every week-day by the surgeons and assistant surgeons at 1.30 p.m. Tuesdays and Fridays are reserved for operations in the theatre, of which notice has been posted in the colonnade. The surgeons at the operations are assisted by their dressers —NO others should stand about in the "well;" and though it is only to be expected that first and second years' men will attend out of *mere* curiosity once or twice, they should particularly remember that frequenters of dissecting-rooms are liable to make the atmosphere of the operating theatre dangerous for open wounds, in spite of every precaution. Then, too, by crowding out senior men they are doing no good to themselves and causing a lot of discomfort to men whose duty calls them to the operating theatre. These remarks hold good also to the out-patient departments and front surgery, and are not in any manner intended to prevent freshmen from attending on these occasions, but merely to point out to them the futility of such a course of action. In former years men went straight into the wards on joining, nowadays it is necessary and customary for them to remain at "the other end," by which is meant to attend Anatomy, Physiology, Chemistry, Physics and Biology lectures, etc., during their first two years before attempting *any* work in the wards.

Surgical ward clerks are required to write reports of their cases on the forms provided for that purpose in the Surgical wards. They should see all their cases dressed, if possible, and note with attention what changes have occurred in the condition of the wound, and are made in the dressings, always asking why, when in doubt. During the take-in, it is advisable for them to be about the surgery and wards. Sometimes they are asked to dress in the surgery, but should take care never to dress a case, however trivial, until it has been seen by one of the dressers, and preferably, the dressers for the week. If this were conscientiously done, many of the lamentable mistakes which undoubtedly do occur, rather through ignorance than carelessness, would never be seen at out-patients' the next day. Such mistakes are, putting protective over hyd. perchlor. gauze, and sending a foul wound away dressed with hot boracic, without ordering the patient to put on lotion as often as required. Mistakes such as these ought, however, never to occur in well regulated firms. When the Surgical Registrar goes the round of new cases, which he does every morning soon after ten, each ward clerk should be at the bedside of his own cases, having already learnt as much about the patient as is possible in the time at his disposal. Taking temperatures is, at the best of times, a somewhat uninteresting labour, but it is none the less important. and morning and evening, the ward clerk should do this task assiduously—never forgetting to shake down the mercury *after* the reading is taken, and then to wash the clinical thermometer in the carbolic lotion provided for the purpose on the ward clerk's table in each ward. Morning temperatures should be taken as near ten o'clock, evening as near five as possible.

In some few surgical cases urine testing will have to be done every day. See that the patient then is put on a "blue ticket," and do the testing in the morning.

Further information as to classes, etc., may be obtained from the Surgical Registrar. E.

ANÆSTHETICS.

Lectures and Demonstrations are given by Mr. Tom Bird and Dr. Silk on the use and administration of anæsthetics; they are open to men who have passed the Second Conjoint Examination or its equivalent, and to Dental students in their second year. The post of "Anæsthetic Clerk" is open to students only who have attended the Lectures and Demonstrations.

THE DENTAL SCHOOL.

The Green Book too modestly states that "Guy's Hospital affords to Dental students all the instruction required for a Licence in Dental Surgery." But it might as readily, and perhaps with greater justice, have established the claim that the Hospital affords them a great deal more; and, had it been in a moralising mood, it might have gone on to say that not only were rights and opportunities thereby conferred, but responsibilities also were imposed on those Dental men who were wise enough to have chosen to be educated side by side with the students of the parent profession.

The position of the Dental student might be stated in a sentence: in two years he has to master the exacting technicalities of his art; he has to attend more lectures than his medical confrère, and, handicapped thus, he must determine that he will not be left behind in the race over that part of the course where they meet on common ground. That it is possible for him to accomplish this has been proved, for Dental men have already taken honourable positions in examinations on general subjects.

Dental Surgery and Dental Anatomy, with General Anatomy and Physiology, must be his studies during the first winter, and the general must on no account be allowed to suffer for the sake of the special subjects. There are many reasons for this. We will state the lowest of them all, that the opposite course has been the direct cause of 75 per cent. of the failures at the more recent L.D.S. examinations. The dissecting-room must be second only to actual Dental practice; and Dental men will do well to learn the "big things" on other men's parts as well as their own particular work, for they will hardly have time to dissect the whole body. Experience has shown that this advice is not so unnecessary as it sounds.

The Dental books that are essential for the winter's work are Tombs' *Dental Surgery* and Tombs' *Dental Anatomy*. For all general work the dental student should use the same books as the medical. Cram books are a mistake.

The Dental House-Surgeons will post a notice in the Conservation-room, asking the "new men" to meet them to talk about the probationary work that each student must perform before being allowed to operate "in the mouth"; and, with the recollection of their own early days fresh in their minds, they will be found the best and most willing of advisers.

A. D. S.

THE COLLEGE.

The idea of a Residential College at Guy's, although first projected in the days of Addison, was not carried into effect until 1890, when, built upon a site fronting the east gate of the Hospital, and connected therewith by a subway, the College was opened in March by Mr. Gladstone. Residence is afforded here for the men holding the senior house appointments and for about fifty other students, who are all under the supervision of the Resident Warden, Mr. Dunn. Particulars as to terms may be seen on page 25 of the Green Book. There are a few vacant rooms, for which applications should be made to Mr. Wells, at the Medical School Office.

The College contains also the premises of the Students' Club, in the reading-room of which there is a Lending Library.

From a report by the Librarian we find that the number of volumes borrowed from the Library from May, 1893, to April, 1894, both months inclusive, is 800. The favourite author appears to be Stevenson, whose works have been borrowed 51 times; next is Kipling, 41; Sarah Eraud, 29; Balzac, 25; Meredith, 21; Badminton (Sport), 20; poems by different authors, 17; Kingsley's works, 17; M. Crawford, 15; works by Q., 15; Charles Reade, 12; Bret Harte, 12; A. Dumas, 12; Ruskin, 11; J. M. Barrie, 11; Mrs. H. Ward, 11; Benson, 11; Darwin, 10; Dickens, 10; Wendell Holmes, 10; E. Black, 10; W. Besant, 9; Zola, 9; Thackeray, 8; Hardy, 8; Mrs. Alexander, 7; G. Eliot, 6; Wilkie Collins, 6; etc.

In addition to the above, the nurses have borrowed, from November, 1893, to April, 1894, inclusive, 184 volumes, making a total for the year of 984 volumes. This includes 47 volumes borrowed from Mudie's Library.

Printed copies of the Library Catalogue may be had of the Librarian, price 3d.

CALENDAR FOR THE WEEK.

TUESDAY, OCTOBER 2ND.

Anatomy, 9 — Chemistry, 11
Dissections, 10 — Surgery, 1.30
Practical Surgery, 4.

WEDNESDAY, OCTOBER 3RD.

Anatomy, 9 — Clinical Surgery, 1.30
Biology. Prel. Sci., 10 — Physics. Prel. Sci., 2
Dissections, 10 — Medicine, 3
Physiology, 11 — Practical Surgery, 4
Dental Anatomy, 4.30

THURSDAY, OCTOBER 4TH.

Anatomy, 9 — Chemistry, 11
Dissections, 10 — Surgery, 1.30
Practical Surgery, 4.

FRIDAY, OCTOBER 5TH.

Anatomy, 9 — Physiology, 12.15
Elem. Biology (Conjoint), 9 — Surgery, 1.30
Dissections, 10 — Medicine, 3
Hygiene, 11.30 — Practical Surgery, 4
Dental Surgery, 4.

SATURDAY, OCTOBER 6TH.

Dissections, 10 — Chemistry, 11
Clinical Medicine, 1.15

Passim.

The Special Students' Number of the Gazette which we publish to-day is intended more particularly to help the newly-entered Students in their early work. We have to thank the Lecturers and Demonstrators, who, in order to meet this end, favoured us with contributions which, we have no hesitation to say, will be found of no inconsiderable value to many of our readers. At the same time, we feel that we owe our old subscribers some apology for the omission of the clinical material from this issue; we found, however, much to our regret, that if the Students' Number were to be a perfect *vade mecum*, much of our ordinary matter had to be sacrificed. Inasmuch, too, as this is the first occasion in the history of the Guy's Gazette on which an attempt has been made to devote the *whole* of our pages to such a production, it is with some amount of trepidation that we await the opinion of our critics.

The Treasurer's Report of Guy's Hospital for the past year, part of which we also publish, will, we feel sure, be interesting reading to many, particularly old Guy's men. It gives copious information on the working of this great institution, which will doubtless come as a revelation to the large number, whose lack of knowledge about the maintenance of the Hospital to which they are attached is, to say the least, astonishing to outsiders. We have been asked to specially draw the attention of old Guy's men to the paragraphs with reference to the admission of new cases, and to the attendance of out-patients, who occasionally suffer considerable inconvenience through being sent up by their medical man on the wrong day, or even at the wrong hours.

During the vacation some changes have been taking place in the Students' Club premises, which will, when completed, considerably add to the efficiency of the Catering Department. The Senior Charity's bedroom has been converted into a spacious beer-room, while the Senior Charity will in future occupy room No. 52. The old beer-room is now used as a still-room, whilst the latter will shortly be utilized as a despatch kitchen. The improvement this will make in the rapidity of the service of breakfasts, luncheons and dinners will doubtless be apparent to everyone. The hot-plate, hitherto occupying no small amount of room in the hall, will be removed to the new kitchen; more accommodation will thus be afforded to members in the hall. No discomfort will result from smells arising from the cooking upstairs, for from experiments made we are assured that there is practically no inconvenience, so successfully does the flue work.

We are informed by the Secretaries of the Students' Club that there are still some tickets left for the House Dinner, to be held in the Dining Hall on Monday, October 1st, when Mr. Durham will take the chair. There will also be present Dr. Wilks, Mr. Lockhart Stephens, who will read his paper before the Physical Society the same evening, the Secretaries of the Physical Society, and several members of the Staff.

To Surgeon-Captain E. C. Hare, I.M.S., of Ganhati, Assam, the Club is indebted for a pair of very handsome horns of a Sambhar head, which was shot in the Central Provinces. These are at present being mounted, and when placed on the walls of the smoking-room will add greatly to their brightness.

The "Students' Calendar," which may now be got from the Medical School Office, will be found of great use to the newly entered Student, as a guide to coming events.

Guy's Hospital Clubs' Union.

THE FORMATION OF THE CLUBS' UNION by the amalgamation of the various Constituen Institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the Clubs and Societies existing at the Hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription, or of a composition fee (See Clubs' Union Blue Book p. 12), to the Clubs' Union, any student of the Hospital can obtain the privilege of membership of all the Constituent Institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situate close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station of the London, Chatham and Dover Railway. It is nine acres in extent and is the head-quarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Under such restrictions as are found necessary by the committees of the several Clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

The ground-man, who is a professional cricketer, has quarters in the pavilion. His duties are to keep the ground in order, to prepare the wickets and lawn tennis courts, and to bowl to such members of the Union as shall be selected by the committee of the Cricket Club. Lockers may be rented on application to the ground-man, at a charge of 5s. for the summer or winter season.

Cheap Railway tickets between London Bridge and Honor Oak Park Stations are issued to members of the Union upon conditions which will be found enumerated in Clubs' Union Blue Book.

THE HOSPITAL "BLUE."—The "Blue" is awarded by the "Blues" committee to members of the five following teams:—Rugby Football, Association Football, Cricket, Lawn Tennis, Athletics, after considering the list of men suggested by the various clubs' committees through their delegates.

"Blues" are awarded so that at the end of each season the Rugby Football team be represented by fifteen "Blues," the Association Football by eleven, the Cricket by eleven, the Lawn Tennis by three, and the Athletic team by a number dependent on the suggestions of the committee of the Athletic Club: (for instance, if the Rugby team at the end of a season contains ten players, who have already earned their "Blue" in the football team, the "Blues" committee will award five new "Blues," so as to make the number up to fifteen).

CONSTITUENT INSTITUTIONS.

THE FOOTBALL CLUB.—President: J. N. C. Davies-Colley, M.A., M.C., F.R.C.S. Rugby—Captain: H. T. Bell. Hon. Secretary: H. W. Dudgeon. Captain Second XV.: A. J. Cleveland and a committee of five, one representing each year. Association—Captain: R. T. Fitz-Hugh. Hon. Secretary: F. J. Lidderdale. Captain Second XI.: M. S. Barker and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over fifty years, the season of 1894–95 being the fifty-first. Very little is known about its early history; it is, however, recorded that when the Rugby Union was formed in 1871, the G. H. F. C. was one of the original pioneers and the only Hospital Club in the movement; it then had a reputation second to none. The Club's position in the Football world was acknowledged by the Union electing J. H. Ewart to serve on its first committee, which included such historic names as A. Rutter (President), E. H. Ash (Hon. Secretary), F. J. Currey, F. Stokes and A. G. Guillemard. Amongst the many brilliant players, who at one time or another have appeared for Guy's, may be mentioned the following International Footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (Captain 1877–78), A. S. Taylor, W. G. Mitchell, and A. Allport (England); H. M. Jordan (Wales); R. Evans (Scotland); and F. O. Stoker (Ireland). In 1874, the Inter-Hospital Challenge Cup was instituted, which Guy's were fortunate enough to secure for the first time. Since its institution, St. Thomas's have held the Cup seven times; Guy's four times—the last occasion being in 1886; St. George's three times; London and St. Bartholomew's twice each; and Middlesex once. In 1891, Guy's, Middlesex and St. Thomas's were left in, the ties not being played out.

With the opening of the Session and the return of many of our members, football discussions will again become rife in the smoking-room, and many times and oft will these questions be asked! What is our team like this year? Any new men coming up? Can all of last year's team play? Till the team is to a certain extent formed, the first question cannot be well discussed in these columns, it is at present a subject more suitable to the smoking-room. The answer to the second question can only be taken from rumour, but if only half of all we hear comes true there may be one or two good additions to our team. Three of last season's team will not be eligible to play, and undoubtedly their places will be hard to fill, but with a little strengthening of our half-back division and forward pack we may hope to have a team that will hold its own with most of the London clubs.

As usual, we shall combine with St. Thomas's Hospital against Blackheath, Cardiff and Swansea. There are no matches arranged with Croydon this year, but new fixtures have been made with Marlborough Nomads, Wickham Park and Northampton, and matches will be played at Leicester, Coventry and Bristol. When

possible, the committee will arrange for three teams to take the field.

During the first week in October there will be one, probably two, trial games, notice of which will be posted in the smoking-room. These games are especially arranged for those entering the Hospital in October, and the committee trust that freshers desiring to take their place in the football of the Hospital, will make a point of playing in these matches. Thus the work of selection will be considerably lightened, and good men will not be passed over. A ball for practice can always be had at the Clubs' Union ground, and the officers of the club will be ever ready to give any information required.

The Association Football Club was instituted in 1882; the Inter-Hospital Challenge Cup in 1885. For four successive years 1885-89 inclusive, Guy's held the Inter-hospital Soccer Cup, and in addition the Surrey County Cup in 1889-90; St. Bartholomew's won the Cup in 1890, 1891 and 1893; St. Thomas's in 1892. Though we cannot number any Internationals among Guy's Association players, yet many well-known footballers have from time to time appeared, such as H. J. Holman, E. J. D. Mitchell, W. G. Mitchell, H. V. Hickman, H. B. Bolus, A. M. Daniel, N. Lavers, A. B. Carter, and N. C. Cooper. There will be a trial match on the Clubs' Union ground on Saturday, October 6th, to enable the committee to select a team for the first match. There will be vacancies in the team for several forwards, a half-back and a goal-keeper, and the committee hope that any men who play Association, and especially new entries since last season, will give in their names to R. T. Fitz-Hugh, the captain, or F. J. Lidderdale, the secretary, before that date. A notice will also be posted in the smoking-room for names. The Inter-Hospital Cup was won last year after a long interval, and must be kept; and as runners-up in the Surrey Cup, the team ought also to bring that home this year. The committee hope that any new men will come forward.

THE CRICKET CLUB.—President: Arthur Durham, F.R.C.S. Captain: C. J. Francis. Secretary: F. J. Nicholls. Vice-Captain: W. I. Hancock. Captain Second XI: J. Moore; and a committee of ten.

Guy's have always done well at cricket, and since the institution of the United Hospital Challenge Cup, in 1882, have held the coveted trophy for no fewer than ten years, from 1884–88 inclusive—the Cup for which is now the absolute property of the Hospital—and from 1890 to the present year. In the first two years of the competition King's were successful; in 1889 St. Thomas's. As may be imagined, with such success we have by far the best results of any hospital. From '86 to '93 we scored in cup-ties alone 5,522 runs to the 2,800 of our opponents, *i.e.*, almost *double* the number. The highest individual scorer was J. C. Shenton with 172, and an average of 91 in cup-ties. The following also have scored a three figure innings: W. J. Scott, F. Colclough, J. H. Joyce, W. I. Hancock, C. J. Francis. In bowling every year there have been wonderful performances. Among the most notable were those of C. H. Rygate, and J. D. Cruickshank, who bowled all the King's wickets down at a cost of only three runs in 1886; of J. H. Bettington, who took seven wickets for twenty-one runs against Bart's in 1890, as did W. G. Mitchell against St. Mary's in 1887; and of J. H. Joyce, who captured twelve wickets for thirty-six against King's and eight for nineteen against Westminster in 1893.

There are many names of note in connection with cricket at Guy's, to mention all of which would crowd out other matter. However, in addition to those above mentioned there are A. J. Clarke, of Mitcham, E. J. D. Mitchell, A. D. Fripp, S. Wacher, Edgar Reid, and the late J. B. Bettington.

THE ATHLETIC CLUB.—President: R. Clement Lucas, B.S., F.R.C.S. Hon. Secretary and Treasurer: H. T. Bell; and a committee of eleven.

The athletic meeting is held every year at Stamford Bridge during the summer session; from amongst the successful competitors, the team to do battle for Guy's at the United Hospitals meeting is selected. Since the institution in 1867 of the Athletic Championship of the United Hospitals—the first inter-hospital competition of any kind—Guy's, who were the first to secure the Shield, have won it on seven occasions, St. Bartholomew's nine times, St. Thomas's five times, King's and St. George's thrice each, and London once. Amongst the prominent athletes who have performed for Guy's, are W. Maltby, who appeared for North *v.* South in the two miles during 1873; A. W. Pearson, J. Reader, J. G. Graveley (1877, hurdles, in which his record, 16¾ seconds, remained unbroken until the present year); L. Stokes, A. S. Taylor, W. G. Mitchell, H. A. Munro, who for four years (1891—94), has won the mile and three miles, in each of which he holds Hospital record; H. T. S. Bell, who has three times (1892—94) won the 100 yards, twice (1892 –93), each the 220 yards and high jump in both of which he holds record, and long jump (1893—94); P. R. Lowe, hurdles (1892—93); F. S. Batchelor, (440 yards, 1893); and E. N. Scott, throwing the hammer (1893—94).

The Cross Country Challenge Cup, which is to be competed for early in 1895, Guy's have held for the past three years. Cross country runs are held every Saturday, and new men wishing to attend, are requested to communicate with H. A. Munro, who can give any information as to locality, etc.

THE LAWN TENNIS CLUB.—President: W. Arbuthnot Lane, M.S., F.R.C.S. Captain: W. I. Hancock. Hon. Sec. and Treasurer: Gerald B. Webb; and a committee of five.

The Lawn Tennis Club has been in existence for about seven years. At present there are grass courts at Honor Oak, and a single asphalte court opposite the "Ship," which is available all the year round. The key of this is kept with the College Porter. The court must

be secured by the member wishing to play writing his name on a list in the Colonnade (see Clubs' Union Blue Book). The Inter-Hospital Challenge Cup was instituted in Jubilee year; it was held by St. George's until 1890—chiefly through the brilliant play of E. W. Lewis; Guy's held it the next two years, St. Thomas's having won it in 1893 and 1894. We have had some excellent players in the Hospital, chief amongst whom were W. Sturges-Jones, W. H. Fisher, G. Biddle, C. R. Colley, W. H. Peake, W. I. Hancock, G. B. Webb, and F. O. Stoker, the last of whom has of late so distinguished himself in the Ireland v. England Championship Meetings. The Club holds annually an open tournament, which is decided during the summer months at Honor Oak; and nearly every Saturday matches are played with some of the leading London Clubs.

THE RIFLE ASSOCIATION.—President: L. A. Dunn, M.S. Captain: R. H. Luce. Secretary: H. Fulham-Turner.

The Rifle Association is now in its third year of renewed life and vigour, and is now going strong. The last season, though the best as regards fixtures and general working, ended rather unfortunately as to matches, as we only won three; but we were deprived of the services of our two best shots. Two Prize Competitions were held, and next October we hope to compete for a Challenge Cup promised by Dr. Pitt. The United Hospitals' Rifle Association also have a prize meeting next month, so that there will be abundant opportunity for new men to exhibit their shooting capabilities. Probably a considerable number of men have served in cadet corps and have already had practice, and it is to these that we must look if we want to win the Inter-Hospital Cup. Old cadets are therefore urged to at once join a Volunteer Corps in order to get additional facilities for practice, more than the Union is capable of affording, and they will then have the advantage of always using the same weapon, which is recognised as essential. Further particulars may be obtained from any of the officers.

THE BICYCLE CLUB.—President: C. H. Golding-Bird, F.R.C.S. Captain: W. J. Henson. Hon. Secretary: C. Reed.

The Inter-Hospital contest for the Shield presented by G. Mellin, Esq., will be held at the Herne Hill Track, on Friday, September 28th, 1894, at 3 p.m. punctually. This Challenge Shield will be competed for annually, and will be held by the winning hospital. The races will be:—

1.—3 miles scratch.
2.—1 mile ,,
3.—20 miles ,,

Guy's, which is affiliated to the United Hospitals' Cycling Association, may send in three competitors for each race. Entrance fee for each competitor, whether he enters for one or more races, will be 2s. 6d. Competitors must wear their hospital colours and will be provided with numbers. Points for the Challenge Shield will be scored as follows—

Each race:

1st place	3 points
2nd place	2 points
3rd place	1 point

First and second prizes will be given in each race. Entries will close on Wednesday, September 19th, by which date the fees must be paid to H. J. MILBANK-SMITH, hon. sec., Guy's Hospital, S.E.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Samuel Wilks, M.D., LL.D., F.R.S. Hon. Secretaries: H. J. Campbell, M.D., J. H. Targett, M.S.

This flourishing Society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital. From a copy of the old laws of the Physical Society, dated 1800, we learn that the Society met every Saturday night, from seven to ten, during the months of October to the following May. Business at these meetings was divided into private, including "matters in which the Society may be concerned," and public, consisting "in the communication of cases and opinions." A fine of sixpence was exacted from a member absent at the "Roll Calls," also from a member refusing "to hold up his hand on one side or the other," to decide any question. Members were divided into honorary, ordinary and corresponding. So much for the old Physical Society, of which an account is given in the *Biography of Guy's Hospital*, by Wilks and Bettany, a work which every Guy's man should possess. It may be obtained from the Librarian, who has still some copies of the first edition, price 10s. 6d.

At the Pupils' Physical Society, which meets fortnightly, on Saturday evenings, once a month a paper on some subject not necessarily of medical interest, may be read by any member, and is followed by a discussion.

"Clinical Evenings" are devoted to the exhibition and discussion of interesting cases in the hospital, which may be shown by any member. The following is the programme for the ensuing session:—

October 1. "Medical Education in relation to General Practice." E. W. Lockhart Stephens, Esq.
October 13. "Diphtheria." W. C. C. Pakes.
November 10. "The Treatment of Skin Diseases by Thyroid Extract." Leonard A. Parry, M.B.
December 8. "Malaria." W. S. Handley.
February 16, 1895. "Sleep." C. H. Fagge.

Members are reminded that in connection with the Society, every year prizes are offered for competition. The Treasurer's Prize of £5 is given for the best essay on "The Pathology of Dropsy." The Society Prizes include a prize of books or instruments of the value of £10, for the best paper read before the Society during the session; a prize of the value of £4 to the member who distinguishes himself most in the discussions, and a prize of the value of £5 to the member who exhibits the best specimens of scientific interest during the session (see Clubs' Union Blue Book, page 38).

THE GUY'S HOSPITAL GAZETTE is the journal of the Pupils' Physical Society, and is conducted by a committee of publication under the chairmanship of J. H. Targett, M.S. A Student member of the Committee is elected by them to act as sole and responsible Editor during such time as the Committee may please. The publication is a fortnightly one, and the present issue only is enlarged to forty pages. The first number was "launched" on October 1st, 1872, and the GAZETTE is thus entering on its twenty-third year of existence. It was the first Students' Journal ever published in this country, and, as far as can be ascertained, is the oldest in the world. It ran an uninterrupted course until 1879—the last number appearing in November of that year, and was then suppressed, rather from excess of zeal than from lack of material. The present "new series" was inaugurated in 1887, and since that time it has continued to flourish without a break. The original GAZETTE was a two-leaf publication; at present it has attained to the proportion of thirty-two pages. The columns of the GAZETTE are open to contributions from all students, old *and* new, and here we cannot do better than quote from the editorial notice of October 1st, 1872: "We would ask all Guy's men to aid us with every information they may think will be useful to their fellow-students. To the Surgical, Medical, and Clinical clerks we shall look for reports of remarkable cases; to the post-mortem clerks for notes of interesting autopsies, and to the others, each in their several departments, for an account of such facts as they may come across, in discharging the duties of their appointments, and may think likely to prove of value to others." To this we would add that reports of the various clubs and institutions now comprised under the "Clubs' Union" are always welcome. For news of matches, then, we must look to the various secretaries, who should make either themselves or some other person qualified to write reports of matches, etc., responsible for assistance to us in this direction.

THE CHRISTIAN UNION (Hon. Secretaries: W. E. Plummer and C. F. Wakefield) consists of men whose principles and aim in life are "Christian." It has been established for over forty years. On Tuesdays the meetings are confined to the spiritual and historical study of the Bible, by members among themselves. On Thursdays the meeting is addressed by a visitor who has been invited for the occasion. The meetings are held, by kind permission of the Treasurer, in the Board-room at 4 p.m. Guy's being represented in the Mission Field, a Missionary Society has been formed, in order that a connection may be maintained between past and present students. By extending their sphere of work, the committee hope to attract the whole of Guy's Students, and are confident that by adequate attention to the teachings of Jesus Christ, a medical man is best fitted for the opportunities that are open to him.

THE DEBATING SOCIETY.—President: F. W. Pavy, M.D., LL.D., F.R.S. Vice-Presidents: A. D. Fripp, M.S. and J. W. Washbourn, M.D. Secretaries and Treasurers; J. M. Fortescue-Brickdale, H. J. Spon; and a committee of three senior and three junior students.

The Debating Society is entering on its third year of existence, and its first as a constituent of the Clubs' Union. It meets once a month, and debates are held on any subject, whether political, scientific, or of general interest, the expression and discussion of theological views, however, is "absolutely prohibited." At the end of the session, a "Ladies' Night" is held, at which lady friends of members are invited, not only to be present, but to take an active part in the discussion. The first meeting will probably be held on the last Saturday in October, the subject of debate on which evening will shortly be announced. Members desiring to bring forward a subject for debate, must forward to the Secretary, their subject, together with the *signature of a member willing to oppose him.* During the last session, debates took place on the "Eight Hours Bill," "Welsh Disestablishment," "Abolition of the House of Lords," "Is it the duty of the medical man in all cases to prolong life?" (Ladies' Night).

THE REPORTS.—Edited by W. Hale White, M.D., and W. H. A. Jacobson, M.A., M.Ch.

The first volume of the Guy's Hospital Reports appeared in 1836. The Reports are now published annually and contain contributions upon professional and scientific subjects from the Staff of the Hospital and Medical School. The volume of the present year is the 50th, and Guy's may well be proud of the fact. No other Hospital has as yet published more than 30 volumes (St. Bartholomew's, the next on the list, has published 29), and one other society only has published more, viz., the Royal Medical Chirurgical Society, which has reached its 75th volume.

THE STUDENTS' CLUB.—President: Arthur Durham, F.R.C.S. Treasurer: C. J. Symonds, M.S. Hon. Secretary: J. Fawcett, M.D. Hon. Assistant Secretary: H. J. Spon. Committee: W. Hale White, M.D., J. W. Washbourn, M.D., A. D. Fripp, M.S., H. T. Bell, C. H. Bryant, A. V. Clarke, B. G. Reynolds, and the President of the Resident Staff.

A full account of the Students' Club rooms will be found in the Clubs' Union Blue Book, p. 46. We are asked to direct attention to the "smoking concerts" which are held every month under the supervision of the Residents. Though there is plenty of tried and valued talent in the Hospital, we should like to see some more junior men coming forward to take an active part in these concerts. When the time approaches for getting up a programme, it is, however, extremely difficult to get new performers, and it is not reasonable to expect the Residents to find out all the talent, so *all* those who would care to sing, recite or play, are requested to communicate either personally or by letter to the Resident who has charge of the particular smoking concert. For the late improvements in the club our readers are referred to "Passim."

The Pavy Gymnasium, which was built and furnished by the liberality of Dr. Pavy, is open daily for practice

and during the Winter Session a boxing instructor attends on each Thursday afternoon, and a gymnastic and fencing instructor on each Tuesday afternoon. At the end of the Session a competition for prizes is held, and a display of gymnastics and boxing and fencing is given by the successful competitors.

The Association Eleven.

IN order to show our appreciation of the good work and success of the XI. during last season in winning the Inter-Hospital Cup after seven consecutive unsuccessful attempts, we produce their photograph (by Russell & Sons, Wimbledon) to-day, from which we regret to say the forms of two of the most prominent members are absent. It was thought that at the same time a short outline of the career of each might be welcome, and this is the object of the present article.

*H. HEWETSON (captain), (half-back or right inside), first gained prominence in the game by getting his colours as a half-back in the Repton XI. of 1886–87, and maintained his position in the following year: his last year at school, however, he did not play. Coming up to Guy's in 1889, he secured his place in the team that year: was hon. sec. for the next two seasons, and captain for his last two years; he was awarded an honour cap for his work in 1891–92. During his five years he has played in nearly all the ties, both for the Hospital and Surrey Cups. He has also some reputation as a cricketer, having played for the Hospital for three seasons, while he has once competed for the Shield in the Athletic team.

A. B. CARTER (left back). We regret that we have been unable to obtain any details of his early training in the game, but he soon took up a prominent position when he went to Cambridge and played regularly in the Jesus team; though he failed to obtain his blue he found a place in several of the trial matches. Since coming down he has often played for the well-known Surbiton Hill team, of which his brother is captain. At times he had found a place in his county XI.; he played regularly for us last season—his first year—in all matches. As a tennis player he was elected a "Grasshopper" at Cambridge, and played for us this year in the Inter-Hospital Ties.

N. C. COOPER (centre half-back), was born at Long Ditton in 1870, and owes his football training to Brighton College, where, after being captain of the junior team in 1884, he passed through the second XI., and was in the first team from 1887–89. He played in the cricket XI. from 1884–89, and in his last season was captain of both the teams. In the season of 1889–90 he gained his colours at Jesus College, Cambridge, and was captain in 1891–92, and altogether played four years, during two of which they held the Inter-Collegiate Cup. He was in the 'Varsity team for three years, being elected captain in 1892–93. Though rather less successful at cricket, he played continuously for his college, and several times for the 'Varsity, just failing to obtain his double blue. Since he came up here he played almost continuously in the "Soccer" matches and ties, but has not done much at cricket; he has occasionally played in the Surrey Second XI., and for the Gentlemen of Surrey; since 1890, he has several times taken part in the Corinthian Football Club's matches.

A. E. CROSBY (left half-back) has taken part in the game from his early boyhood, and having learnt his football at school, played for several of the best known Scarborough clubs, *e.g.*, the Town Club and the Rangers. Since coming up in 1892 he has played regularly and consistently for the team in all matches.

*A. M. DANIEL (right and centre half-back), having played for three years (1883–84–85) in the Repton team, went to Trinity College, Cambridge, and was a constant member of their team; he also gained his "Blue" in two seasons (1887–88 and 1888–89), in the latter of which years a drawn match was played with Oxford. During the legitimate term of five years, he has played in all the Hospital Ties, and has constantly played for both the Crusaders and Surrey, having been captain of both teams.

R. T. FITZ-HUGH (centre, or right inside) learnt his football in a private school, but first played the game regularly at Shrewsbury, when he played one season in the Second, and two in the First XI., when they beat Rossall easily. Having come to Guy's in 1891, he has played for the Hospital for three years; he was secretary last year, and has been appointed captain for the coming season last year he was also vice-captain of the United Hospitals' Association Football Club. On several occasions he has been included in the Surrey team. As a cricketer he played for the Hospital in 1892 and 1893, and in the first season was wicket-keeper.

*C. E. HIBBARD (centre, or right wing), was born in 1869, and was initiated in the game at Dodington College, where he stayed four years; he, however, played under Rugby rules for one year at Clapham Rise Collegiate School, but reverted to the Association game in 1884, when he entered the Chatham team, for which he has played continuously till 1892–93; last season he was one of the New Brompton XI. For Guy's he played continuously for five years, having entered in 1889, and took part in all Hospital Cup Ties—two excepted; he was ineligible for the Surrey Cup competition, as he had been playing in the Kent team. At cricket he was tried for the First XI. when he came up but had more success for the Second; while as an athlete he ran unplaced in the 440 yards race, at the Inter-Hospital sports of 1889 and 1890.

L. HUMPHRY (left wing), first learnt the game when at school at Brighton, but gave up this for Rugby rules when going to Rugby, where he obtained his colours in the XV. of 1892, and also was in the XXII. at cricket. Coming to Guy's in October, 1893, he found he was too light for the Rugby game, and so again took to "Soccer," with the result that after playing for the Second in the early part of the season, he found a place in the First in the later Association matches and ties.

N. LAVERS (goal-keeper) is of Tasmanian extraction: although he had played the Victorian game continuously, had never seen the real Association game until he came over in 1891, but having started playing for the Hospital Second XI. in '92, was soon considered good enough for the First, and played in most of the cup ties that year, which position he has maintained during the past season.

F. J. LIDDERDALE (right back) played very little football during his four years' stay at Charterhouse; did little in the same line while in residence at Trinity College, Cambridge. On coming up to Guy's he began to play regularly, and has successfully occupied the position of right full back in the team for two seasons.

R. B. STAMFORD (left wing) is, like Daniel and Hewetson, an old Reptonian, where he obtained his "cap" in 1889–90. His first season at Guy's he played no football, but in the ensuing season found a place on the left wing, which he has since most successfully retained in all matches and ties. Last season he had the distinction of being awarded an honour cap. He has played for the Hospital at cricket for four seasons, with a good deal of success, and was secretary to the club in the season of 1893.

F. E. WALKER (right wing), when at the City of London School, obtained his "cap" in the season of 1890–91, and was captain for the next season. While at school he always occupied the position of full back, but coming up to Guy's in 1892 he occupied a vacant place on the right wing till Christmas. Last season he played throughout the season in the same place, and took part in all the early ties, but a sprained ankle lost him his place in the finals of both cup competitions.

* Those marked thus are not available for the coming season.

"Salve." (p.a.)

A hearty welcome to you all, from one who's been like you,
A stranger in an unknown land, with hopes and fears in view.
Before you lies as grand a field as man can ever take,
Where you may cull the fairest flowers, and rare discoveries make;
Like many men before have done (our annals glow with fame),
Whose watchword, "keen and careful" was, who worked with steadfast aim,
Right welcome to our Students' Club, the best one ever known,
Providing quite another field, where keenness may be shown.
In football, cricket, or the path, and various forms of sport,
Inspire us with your energies, and heartiest support:
That when this year is ended, we may look with honest pride,
On success in work and pastime, which no other year has vied.

L.O.

Artists Rifle Volunteers.

THERE will be a few vacancies in "G Company" of the above Corps on November 1st, and the attention of new comers is invited to the following particulars:—

The Corps, which last year numbered over 800, has now been in existence for thirty-four years, and is composed of painters, architects, sculptors, students of the various professions, etc. The Corps is well known in London and the Provinces for smartness and general efficiency, and for several years past has carried off first prizes at the Royal Military Tournament in competitions open to the whole Volunteer Force. A distinguishing feature of the Corps is that all the officers, from the Colonel downwards, have worked their way through the ranks, this taking on the average eight to ten years to do; this ensures that the difference between the officers and rank and file is not one of mere wealth, as is so often the case in other corps.

The battalion goes out twice during the year, into barracks at Easter, and under canvas for a week in August. In connection with Easter a three days' flying march is held. The work done by the Corps is not of a medical kind, and it affords a thorough change to a medical student to go from the wards or dissecting-room and spend a week under canvas learning the most approved methods of destroying life in large numbers.

The following sections are open to members:—Cyclist, transport, signalling and ambulance. The Corps is one of the few Volunteer corps possessing its own transport arrangements and able to take the field at short notice. If any member wishes to obtain a knowledge of ambulance work he can join the ambulance section, and rejoin his company ranks when he has had enough of it.

The head-quarters comprise a large drill hall, accommodation for regimental school of arms, and club room for members. The subjects taught in the school of arms include gymnastics, wrestling, fencing, sword exercise, rope climbing, Indian clubs, boxing, etc.

The annual subscription is £1 5s. There is no entrance fee, but each recruit must supply himself with a great-coat. The minimum service accepted is three years. Uniform, equipment and ammunition are provided free by the Government. The standard of height is 5 feet 8 inches, with a chest measurement of 33 inches.

G Company is recruited from the students of the various London hospitals. Two of the Company officers and the colour-sergeant are qualified members of our profession.

Every recruit has to be nominated by a member and approved by the Captain before he takes the oath. As last year the Company numbered 107, there will only be a limited number of vacancies, and smart men who wish to join should communicate with A. J. Collis, corporal in charge of the Guy's section, who will be pleased to arrange to meet them and give them any further particulars they may wish to know. Letters may be left at the letter window at the front of the Hospital.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra amount of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps which have been sterilised by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

J. W. S.—The perineal growth received shows the structure of a condyloma—*i.e.*, there is a complete sheathing of epidermis over a mass of young fibrous tissue. The superficial cells of this epidermis are separating freely, and form with the secretion present, an encrusting pulp. Around the vessels a great deal of small-celled infiltrations with advanced fibrous cells are seen.

L. W., NORTHAMPTON.—The large exostosis is of cancellous structure, and has a very prominent cap of cartilage. The connective tissue covering this is becoming cartilaginous.

C. J. B. M., MANCHESTER.—Many thanks for the specimen from a branchial fistula. The cleft forms a complete tube with an opening at both ends. (Was there an internal opening?) The lumen is covered by a modified transitional celled mucous membrane, four cells thick; it is ulcerated in places. Below this is a submucous layer showing active cell formation, and some inflammation. Mucoid glands are present in this layer. Extending into the submucoid layer are muscle fibres arranged longitudinally with the length of the fistulous cleft. The muscle fibres are mostly in bundles, but a few isolated fibres appear close to the mucous membrane. The muscle fibres are striated. No cysts were seen in the wall.

W. W., SCORRIER.—The breast growth is a spheroidal celled carcinoma, which is slowly infiltrating the surrounding tissue.

R. F. S., ST. AUSTELL.—Tubercle bacilli are present.

L.—Numerous cocci present; but no Klebs Loëffler bacilli.

S.—Klebs Loëffler bacilli were not found in membrane sent.

PATHOLOGIST.

First Meeting of the Physical Society.

PROGRAMME.

6 p.m. Dinner in College Hall (admission by ticket).
7 p.m. Smoking and Reading Rooms with Scientific Exhibition opened.
7.30 p.m. Paper to be read in the Anatomical Theatre by Mr. Lockhart Stephens.
9 p.m. Tea and Coffee—in College Hall.

LIST OF EXHIBITORS.

1. Down Bros. Surgical Instruments.
2. Stanley. Mounting and Photographic Apparatus.
3. Kanthack. Zeiss Microscopes.
4. Swift. Microscopes and Microtomes.
5. Hewlett's Histology Cabinet.
6. Millikin & Lawley. Osteology.
7. Photographic Committee.
8. Hospital Artist.

ORDER OF PROCEEDINGS AT PHYSICAL.

Secretary to read the minutes.
Dr. Wilks in the Chair.
Paper read by Mr. Lockhart Stephens.
Vote of thanks to Reader.
Reader's reply.
Vote of thanks to Treasurer.
Treasurer's reply.
Vote of thanks to Dr. Wilks.
Dr. Wilks' reply.

Appointments.

BENSON, H. Thos., L.R.C.P. Lond., etc., has been appointed Medical Officer and Public Vaccinator to the Market Deeping District of the Bourne Union, *vice* W. B. Deacon, resigned; also Cert. Factory Surgeon.

COLCLOUGH, W. Frank, B.A., M.B., B.C. Cantab., M.R.C.S., L.R.C.P., has been appointed Medical Officer to the British Hospital, Oporto, Portugal.

HASLAM, W. A., L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Medical Officer for the Infirmary, West Derby Union.

HODSON, Frederic, M.R.C.S., L.S.A., has been reappointed Medical Officer of Health to the Hornsea Local Board.

KNIGHT, John T., M.R.C.S., has been reappointed Medical Officer of Health for Carlton.

MORICE, Charles G. F., L.R.C.P. Lond., M.R.C.S., has been appointed Resident Surgeon Superintendent to the Grey River Hospital, Greymouth, New Zealand.

PINDER, George, M.D. Cantab., has been appointed Senior Assistant Surgeon to the South Dispensary, Liverpool.

Guy's Hospital.

DAYS AND HOURS OF ATTENDANCE.

IN-PATIENTS.

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

OUT-PATIENTS.

The days and hours of attendance in the Out-Patient Department of this Hospital are as follows:—

Medical Cases.—Mondays, Wednesdays, and Fridays, at or before 12 noon.

Surgical Cases.—Mondays, Wednesdays, Thursdays, and Saturdays, at or before 12 noon.

Diseases of the Eye.—Tuesdays and Fridays, at or before 12 noon.

Diseases of the Ear.—Tuesdays, at or before 12 noon.

Diseases of the Skin.—Tuesdays, at or before 12 noon.

Diseases of Women.—Thursdays or Saturdays, at or before 12 noon.

Diseases of the Throat.—Fridays, at or before 12 noon.

Diseases of the Teeth.—Daily, from 9 to 10.30 a.m.

The entrance for Out-Patients is in GREAT MAZE POND. A charge of threepence is made for Medicine, and patients must bring their own bottles and gallipots.

No letters of recommendation are required.

PAYING PATIENTS.

Paying Patients are received into the Hospital either into the General Wards at a charge of one guinea a week, or into a Private Ward ("Bright" Ward), in which each patient has a separate cubicle, at a charge of three guineas a week.

Patients applying for admission to the General Wards must inform the Superintendent of the nature of their ailment in order that he may judge whether they are suitable cases to be taken into a Hospital, and before they can be admitted, a Form of Security must be signed either by the applicant or by some one of assured respectability, who will be responsible for the weekly payment of one guinea to the Superintendent. This charge is an inclusive one, and entitles the patient to all the privileges of the Hospital with the corresponding obligation to conform to its rules and obligations. Patients who have arranged with the Superintendent to be admitted must arrive at the Hospital before 5 o'clock in the afternoon.

Patients desiring to be admitted to "Bright" Ward must apply to the Superintendent either personally or through one of the Physicians or Surgeons of the Hospital. When admitted, they will be under the care of a Resident Medical Officer specially appointed to attend them. Each patient is provided with a separate sleeping compartment, comfortably furnished, together with maintenance and nursing. The charge for the same is three guineas a week, which must be paid in the Superintendent's Office. Part of a week will be charged at the rate of nine shillings a day. In the event of isolated accommodation or extra nursing being required, the ordinary weekly charges will be proportionately increased. Patients may be visited by their friends any day between the hours of 10 and 12, and from 2 to 6 o'clock. They are required to bring their own towels and soap, and to pay their own laundry expenses. They may not bring more luggage with them than can be contained in a small portmanteau or bag. They must conform to the regulations prescribed by the Governors of the Hospital for the good order and comfort of the Ward. It is to be understood that, if a patient desire medical or surgical treatment beyond that provided by the Resident Medical Officer, he must make his own arrangements as to fees with one of the Hospital Physicians or Surgeons, or he may, if he so desire, be attended by any other Consultant, subject to the approval of the Superintendent.

TREASURER'S REPORT FOR THE YEAR ENDING LADY-DAY, 1894.

In submitting to the notice of the Governors, Contributors, and other Friends of the Hospital his Eighth Annual Report the Treasurer ventures to express the hope that the various alterations effected during the past year may promote the usefulness of this great Institution which is more particularly entrusted to his charge, and may furnish an additional claim, if such were needed, upon the support of the benevolent public, without whose active and continuous co-operation the work of the charity even upon its present somewhat contracted basis cannot long be continued. When the fact is realized that the expenditure of the Hospital during the past year has been £12,872 in excess of the ordinary receipts, it is evident that the need for help is urgent.

Proceeding to review the events of the past year the Treasurer has in the first place to express the regret of himself and of the Governors at the retirement of Mr. Arthur E. Durham from the post of Senior Surgeon in accordance with the old established rule of the Hospital which requires that every Physician and Surgeon shall vacate office at the age of 60 years. In acknowledgment of his long and distinguished services Mr. Durham was placed upon the Consulting Staff immediately upon his retirement. Mr. Golding-Bird has been promoted to the post of Surgeon to the Hospital, the appointment of Assistant Surgeon thus vacated being filled by the election of Mr. L. A. Dunn, M.S., late Senior Demonstrator of Anatomy.

In the early part of last September, Mr. Prier, the first clerk in the Superintendent's Office, who had been in the service of the Hospital for more than 50 years, had a paralytic seizure, and though it was at first hoped that he would be able to return to his duties after a period of rest, this expectation was not realized, and at the end of the year Mr. Prier asked permission of the Court to resign his appointment. Reluctant though they were to lose so valuable a servant, the Governors felt that at the age of 71 Mr. Prier might reasonably be allowed to lay down the cares of office, and in consideration of his protracted and faithful service they

granted him a pension equivalent to the moderate salary, £220 per annum, which he had enjoyed for the last 19 years of his engagement. Since his retirement Mr. Prier has received an address signed by the Treasurer and by many of the Medical and Nursing Staff, by his colleagues in the Counting House and in the Superintendent's Office, and by others connected with the Hospital, who esteemed his inflexible integrity of character, his ever vigilant attention to those small details upon which the economical management of a great Institution depends, his courageous defence of whatever appeared to him to be right, and, in short, his life-long endeavour to make the administration of the Hospital, so far as it depended upon himself, conducive in the highest degree to the relief of the sick and suffering.

During the past year considerable changes have been made in the Nursing department. The appointment of a new Matron gave the Treasurer the opportunity for a revision of certain arrangements in the Matron's House, which though well adapted to the circumstances of the Home at its inception, might, as he thought, be modified with advantage in the light of a wider knowledge derived from experience. In accordance with Miss Nott-Bower's wishes an allowance has been made to her for board and house-keeping, and the supper of the Lady Pupils is now provided, in the Medical Building instead of in the Home as heretofore. By these and other modifications of previous arrangements it has been found possible to dispense with one servant in the Home, and considerable economies have been effected in the cost of provisions and of fuel.

Towards the end of last March a small fire occurred through a defect in a flue in the roof of the Nursing Home. It was extinguished without difficulty and very little damage was done, but as the chimney stack containing the defective flue was found to be far out of the perpendicular, it was thought advisable to rebuild it, and advantage was taken of the necessary scaffolding and appliances to rebuild two other stacks, which it seemed might in the course of a few years become dangerous. Moreover, fire-extinguishing apparatus similar to that already provided throughout the wards was furnished to the Home, and every three months the Nurses and Hospital Officials receive instruction from a competent fireman, sent by Messrs. Merryweather & Sons, in the use of the various appliances.

Another important change has been made in the administration of the Matron's department. In place of the so-called Extra-Sister, whose duty it was to help the Matron in her work, and whose tenure of office was commonly a brief one, it has been found desirable to appoint a Lady with the status of Assistant Matron, who in the absence of the Matron acts with her authority, and to whom under the general supervision of the Matron much of the routine work of the Office is entrusted. Such an arrangement is known to work well at many other Hospitals, and with the ever-increasing importance of nursing, it is no longer possible for the Matron of so large an establishment as Guy's, however energetic, to carry on her work single-handed, and to maintain the Nursing School in its proper position, without the assistance of able subordinates to take charge of the various departments.

In the year 1889 the Governors, upon the suggestion of the late Superintendent, Dr. Steele, federated with the Royal National Pension Fund for Nurses for the purpose of encouraging thrift amongst the Sisters and Nurses of the Hospital, and of assisting them in making some provision by way of pension against old age. It was hoped that most of the Nurses upon the Staff of the Hospital would make an effort to put by the sum necessary to produce a pension of £7 10s. at the age of 55 years, if an equal contribution for this purpose were made by the Hospital, the more so as it was arranged that under certain conditions the money could be taken out of the Fund, should the Nurse leave Guy's, or withdraw from her profession. As a matter of fact these expectations were but very partially realized, and in the early part of last year the existing scheme came up for revision. It was then arranged that, though the Nurse was still required to contribute for a pension of not less than £7 10s., the Governors, following the precedent of the London Hospital, would assist the Nurse to the extent of £11 5s., thus raising the total minimum pension from £15 to £18 15s. per annum. Moreover, in accordance with the general feeling upon the subject, the age at which the pension should become due was altered from 55 to 50 years, and the further concession was made, that, should a Sister or Nurse leave the Hospital for any cause whatever, she should still be entitled to withdraw both her own and the Hospital premiums a year afterwards, according to the rules of the Fund. This provision appeared to the Treasurer to be both liberal and just, and as the result of these modifications a greater number of Sisters and Nurses have joined the Fund. There is, however, still room for improvement in this respect, and the Treasurer cannot but hope that, when it is generally realized how large an inducement to thrift is held out by the scheme, participants will be more numerous. To take a concrete example—if a Nurse join the Fund at the age of 30, she has to contribute £4 18s. per annum for a pension of £7 10s. at the age of 50 years, and the Hospital at the same time pays to the Fund on her behalf the sum of £7 6s. per annum, which sum is practically an addition to her salary, since the accumulated premiums may be withdrawn by her from the Fund if she give up nursing; may be disposed of as she may direct, should she die before entering upon her pension; or finally, if she continue her career as a Nurse, are invested in the most profitable way as a provision for her declining years. The establishment of the National Pension Fund for Nurses, towards which three of the Governors of Guy's Hospital so largely contributed, has without doubt acted as a powerful stimulus towards the formation of habits of saving, and, now that the injurious statements regarding the Fund and its management, which for some years past have been industriously circulated amongst Nurses, have been by legal process abated, there is reason to

suppose that its advantages will commend themselves even more strongly to the class whom it is designed to benefit.

With the view of inducing more Nurses to remain in the service of the Hospital after the completion of their three years' training the scale of remuneration has lately been modified. Under the old arrangements Probationers received £12 for the first year, and £18 for each of the succeeding years of their training, and they were thus paid disproportionately well in comparison with the Nurse who on completion of her training only received £20 per annum, beyond which sum there was no definite prospect of increase, though as a matter of fact several of the older Nurses were in receipt of £25 per annum. In comparing these salaries with those given elsewhere, it must however be remembered that at Guy's a Nurse is provided with in and out-door uniform, and has her laundry free. The new scale for Staff Nurses is as follows:—£25 for the fourth year, £28 for the fifth year, and £30 for the sixth year of service in the Hospital. Moreover, a Nurse is encouraged to join the Pension Fund, and if she does so at the age of 28, she receives indirectly an increase of £6 9s. a year to her salary. On the other hand, the remuneration of Probationers has been diminished so as to be £8 for the first year, £12 for the second year, and £18 for the third year. It is with a feeling of great reluctance that the Treasurer has had to make this reduction in the wages paid to Probationers, but, having regard to the poverty of the Hospital, he did not feel justified in asking the Governors to do more than to assent to a measure redistributing the sum to be expended upon the Nursing Department.

In September of last year the dietary of the Nurses was improved by the addition of pudding every day for dinner, of dessert on Sundays, and by a cold meat supper on three instead of on one evening of the week. It is now as follows:—

BREAKFAST.—Tea, Coffee, or Cocoa; Bacon, or Fish, or Sausages, or Brawn, or Eggs; Bread and Butter.

DINNER.—Meat, two Vegetables; Puddings, or Tarts; Milk or Beer.

AFTERNOON TEA.—Tea; Bread and Butter.

SUPPER.—Cold Meat or Soup; Cheese; Bread and Butter; Milk or Beer.

The dietary, as thus amended, appears to be much appreciated by the Nurses, and great care is taken, not only that the meals may be well served, but that there may be as much variety as possible in the dishes brought to table. The health of the Nurses during the past year has been exceptionally good. The Nurses' Sick-Room in the Clinical House, overlooking the Park, has had some necessary additions made to it, has been repainted, and in great part refurnished, and on its wall are hung pictures procured by the kindness of Mr. J. W. Butterworth, one of the Governors, from the Council of the Art Union of London. In the Dining Hall chairs have lately been substituted for the somewhat archaic and uncomfortable benches hitherto in use. The Treasurer has every reason to believe that the changes above enumerated, and many other small improvements initiated by Miss Nott-Bower, have been much appreciated, and that they have contributed greatly to the health, comfort, and efficiency of the Nursing Staff. As showing the continued popularity of the nursing profession with the public, and the appreciation in which "Guy's" is held as a training school, it may be mentioned that during the past year the Matron has received about 2,500 applications from would-be Lady Pupils and Probationers.

Considerable attention has been devoted during the last twelve months to the Dispensary. In the early part of 1893 the notice of the Treasurer was directed to the large amount of money expended in supplying aerated waters to the wards. Not only did the materials —bicarbonate of soda and tartaric acid—cost about £30 per annum, but considerable sums had periodically to be spent in repairing and renewing the damaged and broken gasogenes, by means of which the Nurses in each ward manufactured the soda water and lemonade required for their patients. Accordingly, after a careful consideration of the whole question, the Treasurer decided to purchase the necessary plant to prepare the aerated waters in the Dispensary. The initial cost of the machine, filter, syphons, etc., came to £99 8s., repairs and breakages for the ten months ending December 31st, 1893, £2 5s. 4d., and the actual materials used during the same period, £17. The labour necessary to fill the syphons has been provided without extra expense to the Hospital by the Dispensary Porter, assisted in the summer months occasionally by the Gardener. It is interesting to learn that the number of syphons filled between March 1st and December 31st, 1893, was 21,664, the highest number emptied in one week being 959 (August 13th—19th), and the lowest, 241 (March 19th—25th). It is found as a matter of experience that, on the average, six dozen syphons are filled in one hour.

The problem how best to dispose of kitchen and ward refuse, together with soiled dressings, poultices, etc.—and last, but in the summer months not least, withered flowers—is one which presents some difficulties to the managers of Hospitals, especially of those situated in large towns. It is generally agreed that destruction by fire is the best method when available, and during the past year Mr. Kirkland, acting as engineer for the Hospital, has devised a very satisfactory form of destructor furnace which has cost about £100 in erection, has effectually disposed of all refuse, and has resulted in a saving of thirty tons of coal in the six months during which it has been in use. The heat from the furnace passes along the flue of a boiler, and generates steam to drive the engine employed to pump water from the artesian well, and to work the machinery in the laundry. It is found that in the winter months the ashes and refuse from the wards and kitchens are sufficient, with the addition of a little coal, to keep the furnace in full activity from nine o'clock in

the morning till two o'clock in the afternoon. The clinkers and ashes from the furnace have been used for the purpose of raising the level of the paths in the "Park," and thus a very necessary improvement has been effected with a minimum of outlay.

Since the report of Dr. Parsons to the Local Government Board, published in the year 1885, it has been generally admitted that disinfection, if it is to be carried out thoroughly, must, as regards many articles, be effected by superheated steam. Accordingly it had long been an object of desire to erect in the grounds of the Hospital an apparatus of the latest pattern for this purpose to replace the dry heat method hitherto in use. As, however, the cost of the machine was about £300, exclusive of the building required to house it, the Treasurer hesitated to advise the Governors to undertake it at once. By a fortunate coincidence the St. Olave's Board of Works, feeling the need of a similar apparatus, and finding themselves in some difficulty as to a site for the same, entered through their Medical Officer of Health into negotiations with the Hospital, and agreed to erect an L-sized Washington-Lyon Disinfector at their own expense, the Hospital to provide the necessary building, which has been constructed, upon a piece of spare ground remote from the wards and close to the laundry. Moreover, the Board has agreed to pay £100 per annum for the use of the disinfector when not required for Hospital purposes, the Hospital supplying the steam.

(To be continued.)

Guy's Hospital Dental Department.

PRACTICE DURING JUNE, 1894.

Gold Fillings	479
Amalgam, Osteo, Perm. G.P.	532
Dead Teeth	131
Artificial Crowns	39
Scalings	53
Regulations	1
Dentures	11
Attendance for Extraction under Anæsthetics	806
,, ,, without ,,	605
Total	2657

PRACTICE DURING JULY, 1894.

Gold Fillings	438
Amalgam, Osteo, Perm. G.P.	587
Artificial Crowns	64
Dentures	17
Dead Teeth	205
Scalings	75
Attendances for Extractions under Anæsthetics	459
,, ,, without ,,	641
Total	2486

PRACTICE DURING AUGUST, 1894.

Gold Fillings	212
Amalgam, Osteo, Perm. G.P.	307
Artificial Crowns	33
Dentures	13
Dead Teeth	89
Scalings	23
Regulations	3
Attendances for Extractions under Anæsthetics	903
,, ,, without ,,	639
Total	2222

Recent Publications.

Cheyne (W. W.). The Treatment of Wounds, Ulcers, and Abscesses. Cr. 8vo. Pentland. 3s. 6d.

Gould (G. M.). An Illustrated Dictionary of Medicine, Biology and Allied Sciences, etc. 4to. Baillière. Net, 40s.

Pharmacopœia (The) of the Hospital for Diseases of the Throat (Golden Square). Edited by F. G. Harvey. 5th Edition. Fcap. 8vo. Churchill. 2s. 6d.

Thorowgood (J. C.). Asthma and Chronic Bronchitis. Cr. 8vo. Baillière. 4s.

Tomes (C. S.). Manual of Dental Anatomy, Human and Comparative. 4th Edition, 235 Illustrations. Cr. 8vo. Churchill. 12s. 6d.

STUDENTS entering the wards for the first time should supply themselves with a copy of the Guy's Hospital Pharmacopœia. It may be obtained at the Medical School Office.

Birth.

LUND.—On August 29th, at Sandywood, Pendleton, Manchester, the wife of Herbert Lund, F.R.C.S., of a daughter.

Marriages.

HOLMAN—WALLIS.—On the 12th instant, at St. Saviour's Eastbourne, by the Rev. Canon Whelpton (vicar) assisted by the Rev. C. Crowden, D.D., and the Rev. E. D. Cree, M.A., Henry James Holman, M.R.C.S., L.R.C.P., elder son of Henry Holman, Esq., of East Hoathly, to Florence Alice, second daughter of George A. Wallis, Esq., J.P., C.E., of Fairfield Court, Eastbourne, Sussex.

ROBERTSON-RANDLES.—On August 29th, at Brixton, John Robertson, M.A., M.D., eldest son of William Borwick Robertson, M.D., of West Dulwich, to Annie, eldest daughter of the late Edward Randles, Esq., of Durban, Natal.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual subscription to the Gazette *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers, who may be desirous of having their numbers of the Gazette *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette.

OCTOBER 6, 1894.

The Physical Society.

FIRST MEETING.

It may be premised that the first meeting of the Session, held in the Anatomical Theatre on the evening of the 1st inst., under the presidency of Dr. Wilks, was a pronounced success. From start to finish an air of buoyancy pervaded the proceedings. A crowded audience had assembled to greet the guest of the evening, Mr. Lockhart Stephens, the Treasurer, and members of the Staff, amongst whom, in addition to the Chairman, were Drs. Pye-Smith, Taylor, Savage, Shaw, Washbourn, Starling, Campbell, Fawcett; Messrs. Durham, Davies-Colley, Brailey, Turner, Dunn, and a large number of old Guy's men. Dr. Campbell having read the minutes of the last meeting,

Dr. Wilks, as President of the Society, proceeded to make those few remarks for the benefit of new members which were expected of him on this occasion. He would confine himself to pointing out some of the advantages connected with the profession, and the great opportunities presented for useful and noble work. The profession was sometimes reproached for its trade propensities. Well, of course there was a material side, and rightly so. Nevertheless, it was not pleasant to read of sixpenny dispensaries, and other things by which some doctors destroyed their professional brethren. Instead of this kind of rivalry, he would like to see them combine, and the British Medical Association resolve itself into a parliament, where all these matters might be discussed—that the profession should become a trades' union in fact, and, if need be, go on strike. Passing from the disagreeable side of things, which it was not necessary for students to dwell upon, Dr. Wilks proceeded to discuss the opportunities which lay before them when qualified. There was the duty to the individual patient, the consideration of the public health, the discovery of disease germs, and, if possible, of how immunity might be obtained. All that came within the scope of the doctor at the present time; but what the future might require of them it was hard to say. At any rate there were potentialities in medicine, physiology and pathology to exceed past performances. The tendency of the times was in the direction of Socialism, and there was no knowing how far the people might go on placing their individual liberties under the control of Government, with a view to the general good. The rising generation of medical students might, therefore, be called upon in the future to give information respecting many vital questions affecting the health of the State. There was the question of heredity and crime, of the poor half-starved woman bringing forth children. The present social movement might look into some of these things. They had been considered before now, and the Spartans had left us an example of what precautions might be taken to insure the health and strength of the people upon which the welfare of a nation depended. He did not think the time had quite come when marriages and courtships would have to be referred to the County Council, although he had been reading lately that shaking hands and kissing had been made offences in Russia, but he did not think when people in this country wished to perform these processes that they would be required to do so under the strictest antiseptic precautions.

Dr. Wilks next went on to insist, as of old, on the necessity for a medical man to be of good character. He knew of no more noble position than that of a medical man respected by those around him as the custodian of the health of the people; but if he was to be thus respected, his moral character must be good; he must be a shining light. He had seen the doctor of small means and modest qualifications, but whose devotion had caused him to be beloved in life and deplored in death. He saw another man holding a far higher position than the first in the medical world, a cleverer man, one who could amass wealth, but who had lived a selfish life, going down to the grave unwept, unhonoured, and unsung. After paying a high tribute to the late Sir Andrew Clarke, as a great example of the true type, Dr. Wilks concluded by an appeal to his hearers to remember that they owed a debt to the honour of the profession

as well as their own. There was a strong hereditary tendency at Guy's Hospital, for it was born amid a spirit of enthusiasm, and that had been perpetuated. Generation after generation passed away, but the immortal part of the charm remained and still goes marching on, and that spirit of enthusiasm would now, he trusted, enter into those new members who heard him, and that they would in turn transmit it to others, and that the work they did here would add to the lustre, and perpetuate the name and traditions of Guy's Hospital.

The President then called upon Mr. E. W. Lockhart Stephens to read his paper on

"MEDICAL EDUCATION IN RELATION TO GENERAL PRACTICE."

Mr. President and Gentlemen,—It is customary upon a great occasion like the present—and the opening of the Medical School of Guy's Hospital is a great event in the lives of those who are now entering the profession—for the reader of a paper or the person who is to deliver an address to express (1) his gratitude for the honour conferred upon him, and (2) a deep sense of his own unworthiness to perform the task allotted to him. I feel bound to observe this custom, for the Presidents of the Physical Society, putting aside the practice of former years, have forsaken the golden fairyland of the West End consultants, or even the placid affluence of the large provincial towns, and have directed their kind invitation to one who can only claim to be a "country doctor"—a "general practitioner"—but still a Guy's student. I desire to acknowledge very sincerely the honour paid through me to the Guy's general practitioners.

In attempting to collect and put on paper my ideas on this wide subject of Medical Education, I could not but be conscious of my own weakness, of my inability to reach anything like the lofty height of such an address as that delivered here in 1868, by the late Dr. Moxon, and which I ask you all to read, if you have not already done so (you will find it in the Gazette of January last, and in that charming volume, "Pilocereus Senilis"), or even how powerless I was to offer you such valuable advice, as did my distinguished predecessor, Dr. Beale. The work of a general practitioner is to deal, not only with patients who are victims of well-marked diseases and injuries, but with that much larger section who are "out of sorts," a very ordinary line of practice, so that I can have only ordinary observations to offer you.

All students entering at a medical school divide themselves into two great classes: (*a*) those who intend to take a degree at one of the Universities; (*b*) those who intend to take the qualification of the Conjoint Board.

In time the standard of preliminary education will probably be raised to the level of the Matriculation Examination of the University of London which, to my mind, should be the minimum of general education required. Still more do I wish to see the scientific education raised to the level of the Intermediate Examination—the old Preliminary Scientific as we used to call it. It seems impossible that a proper understanding of medicine and surgery can be attained without such scientific knowledge acquired upon a scientific plan.

The old days of empirical teaching have passed away, and at the present time the arrangements at all the medical schools are such that the education of the students is conducted upon scientific principles. There is not a subject in the whole curriculum which can be taught empirically; all must be studied as sciences. The whole standard of medical education has been raised according as our knowledge of the subjects comprised in the education has been extended. Hospital education differs from school life in that the student is within certain limits his own master—happily not quite as much his own master as he used to be—for just as in later years you will see how few men are really capable of conducting a practice or of making one, now there are some who are not capable of regulating their own studies. I advise you in such a case to seek out the Dean of the School, lay your case before him and abide by his advice. You are not asked to do what is impossible; you are only asked to do what others have done before you. Work hard and quickly. All the classes and demonstrations in the world can not supersede personal effort. You have set yourself to do a certain thing in a certain time, and the Conjoint Board have decided wisely that five years is the necessary time, and in the words of the gentleman of the Old Kent Road renown, "It don't seem a day too much." These five years are but the commencement of a lifetime of work, and happy work too. You may not gain much of this world's goods; ours is not the calling in which to amass wealth; but if you can feel the satisfaction which comes of having done your best, honestly and without fear or favour, then you will be rewarded with a happiness such as hardly any other calling in life can bring to you.

When you enter a great medical school like Guy's, you are admitted to very great privileges, and great privileges carry with them equally great responsibilities. Among the many privileges of being a Guy's man I will enumerate a few. You become a member of almost the oldest Medical School in the country, a School which has made and maintained a world-wide reputation, which can point to such names as Astley Cooper, Bright, Addison, Gull, and Wilks, as having done their life's work there; a School where the teachers will teach you of their very best, all they *can* teach you in fact; where a poor student can succeed equally well with the rich. Such is the spirit of Guy's. Then to turn to the more mercenary aspect of the picture, the School offers annually no less than £480 in prizes, and appointments of far greater value, so great that in applying for appointments after leaving the Hospital, a student can say: "There is my work. I want no favour." And in very many instances he gains the appointment. I know of an instance where a Guy's man who had held the senior appointments, applied for the post of house surgeon to one of the largest provincial

hospitals. He had no interest, and he refused to canvass the committee—cut of nearly fifty candidates, many of whom held higher qualifications than his, the Guy's man was unanimously elected. Such was the opinion held, not of the individual, but of the appointments he had held at Guy's.

So that you are to be congratulated on having entered Guy's Hospital.

Before making any remarks upon medical education proper, I should like to state an opinion that before long it will be found necessary to insist that all subjects which belong more properly to general education should be learned before entering at a medical school. The time for mastering the principles of such vast subjects as Anatomy and Surgery, Physiology and Medicine, is none too long; so that much of the good to be derived from a large hospital is lost to students, if they have to spend their first year in studying Physics, Elementary Chemistry, etc. On the other hand, it is most important that the fundamental truths of Natural Philosophy should be known to all, for without such knowledge it is impossible for any man to study and practice his profession intelligently. A student who has been grounded in Elementary Science, commences his more special work with a mind trained to a proper habit of thought and prepared to follow the inductive reasoning upon which scientific medicine is founded. He has learned *how* to study such subjects as Anatomy, and he has such a knowledge of the sciences which are indispensable in attempting to study Physiology.

In the presence of so many who are better qualified to discuss the subject than myself, I feel on very delicate ground when I allude to Anatomy, your first subject.

Formerly Anatomy was regarded as about the most important subject to be learnt. In Mr. Jacobson's masterly account of the life of John Hilton, in the Reports for 1893, you will read this sentence:—"Anatomy in 1828 occupied an infinitely more important position in the early training of a medical student than it does now." These are very weighty words, coming from one of such experience both as a teacher of Anatomy and of Surgery, one to whom I, in common with many a past student, owe so much. Anatomy should still be the chief stay of your after work; not a mere conglomeration of details, but a science. By careful and systematic work at Anatomy you learn not merely its application to Surgery and Medicine, but also you learn to observe accurately the many details of its various branches. You will remember, perhaps, that wonderful and impressive chapter in Ezekiel: "The vision of the dry bones," when the prophet of old was asked, "Son of man, can these bones live?" Gentlemen, the dry bones *must* live if you are to know your work properly. Moreover, it is absolutely incumbent upon you to sustain the honour of Guy's in Anatomy, for many great names have been made here in the science of Anatomy; Sir Astley Cooper, who wrote that wonderful monograph on the "Anatomy and Surgical Treatment of Inguinal and Congenital Hernia"; Mr. Cock, who wrote "Dissection of the Vessels and Nerves of the Head, Neck and Chest"; and Mr. Hilton, who gave the world those marvellous lectures of his on "Rest and Pain," the man who above others could make "dry bones live," who prepared the dissections from which the celebrated models were made at which "all the world wondered." Let me, then, beg of you to work hard at your Anatomy; it will be your sheet-anchor in practice of all kinds. Listen to the words of Sir Astley Cooper: "Let it be always remembered that operations cannot be safely undertaken by any man unless he possesses a thorough knowledge of Anatomy. This is the real groundwork of all surgical science." Later on he says, "When you dissect, take the portion which you are examining, inspect it with care, and note down your observations."

Yes, take notes of your dissections, for in that way you will become possessed of a knowledge of Anatomy which in after years will take you back—not to a particular page of Ellis or Gray, but to a part where you will have a clear mental picture of the actual structures. In practice, gentlemen, it is "dissecting-room" anatomy, not merely "text-book" anatomy you want, and the only way in which to acquire it is by direct original observation, by solid hard work, and by taking notes of your work. Read the preface to your Ellis: "It's purpose is to teach the anatomy of the human body by *dissection*." I am told that men no longer *dissect* as they used to do. If this statement is true, and not merely the jaundiced view of one who has had something to do with the teaching of Anatomy, it is a very serious matter, a very serious defect in the system of education. The kind of knowledge of Anatomy you should aim at is such a complete practical knowledge of the human body that in time you can go straight and quickly for any part required just as easily as a smart and intelligent London cabman will drive you to any address you like to give him. He carries in his mind the point he has to reach, and can tell you every street, and square, and corner he has to pass until he gets there. On thinking over this subject of dissections, I can call to mind two classes of men and two ways in which they used to dissect. The first class would read up their part, study it, and having obtained a good general knowledge of the part and where things ought to be, proceed to "get them out." The other class make a complete hash of the whole thing, cut away things which ought to have been left, and save things which are of no importance, and in the end know nothing about the part. I think I hear someone remarking, "Yes; but perhaps you will kindly tell us what all this has to do with general practice." Well, it is one way of saying that there is a right and a wrong way of attacking and mastering every subject in the curriculum. As I have already said, the time is too short to make mistakes as to *the way* of learning your work. In the country just now we are very much alive, by means of the rates, to the existence of county councils and technical schools. In these schools I believe the first thing they do is to teach the lads the uses of the various tools required in different trades, and then to show them how to use them. So you must be taught

how to dissect, and not merely *what* to dissect. A slovenly dissector will never make a good surgeon, and certainly not a good general practitioner.

There is one subject with which you will have to become acquainted, which, if memory serves me right, did not receive as much attention in my time as it deserved. I mean *Materia Medica* and *Practical Pharmacy*. A good knowledge of the main principles of therapeutics is absolutely indispensable in general practice—you will see many more medical cases than surgical, or to use the words of a very able country doctor whom I know, "You will find you can earn more with a half-crown stethoscope than with a cartload of surgical instruments." At all events, dispensing forms no inconsiderable part of the work in actual practice. Would that it were otherwise!

All work is honourable, it is true, but I must candidly confess that I think a man who has a keen interest in his profession ought to do something which requires a little more intellectual exertion than the compounding of a certain number of mixtures and powders as a part of his day's work. Every practitioner should lose no opportunity of trying to teach his patients that they pay him for his advice and not for his medicine alone.

A knowledge of *Hygiene* is all important, for general practitioners especially have not only to treat disease but to prevent it if possible. To accomplish this end you should endeavour to keep in touch with the Medical Officer of Health in your district; render him all the assistance in your power, for the knowledge of the one will supply the wants of the other, and jointly you will render a great service to the community. In this subject especially your knowledge of physics and chemistry will stand you in good stead.

I now wish to say something on what may fairly be called the general practitioner's speciality—*Midwifery*. Whether all have moved with the times, and have adopted the strict antiseptic precautions which are now recognized as incumbent upon all accoucheurs, is more than I am prepared to say. I fear not. There should be the most scrupulous surgical cleanliness in everyone and everything about a parturient or lying-in woman. You should be just as particular over a confinement as a hospital surgeon is over an ovariotomy. We know what antiseptics have done in that and in all other kinds of surgical practice, and we cannot but feel sure that it will be the same in midwifery when the practice is universal. In many instances parturition is a natural and purely physiological process; it will be a part of your education to recognize what is normal, and to know when to leave well alone, not to interfere unless some interruption in the natural course of labour occurs. Beware lest a long run of normal cases should make you careless or indifferent, and you are, so to speak, caught napping. There can be no situation so painful and distressing as when a practitioner reflects that owing to some neglect or oversight on his part, a patient suffers from fever, or even succumbs to the exhaustion of labour. I do not say that all deaths in midwifery practice are preventable. Far from it. There are cases which foil the most consummate skill; there are some which are too complicated for some, but which might have been brought to a successful termination by others, where, alas! the skilled help frequently arrives too late. Many a man in beginning practice has his future made or marred by the manner in which he conducts his first few cases of labour. One of his difficulties to be overcome will be a certain class of monthly nurse, frequently met with in the country, who is in many cases the personification of all things septic and objectionable. They do not *understand*, and will not be *taught*, the importance of the antiseptic douche before and after labour. Their influence with a patient is very great. I do not know why it should be so, but there are very few women who will not listen to an old monthly nurse and do what she says in preference to what the doctor says. I should like to see at least six beds in the Hospital devoted entirely to lying-in cases for educational purposes, the nurses to be trained in midwifery work, and the students to be instructed in the management of normal labour. It is generally supposed that on commencing his work as extern, the student is accompanied by the Junior Charity to his first few cases. I have not the slightest recollection of such a thing occurring to me, either as extern or as charity. But of course all this is different now. Would not the expense of maintenance of these six beds be more than compensated by the good derived from the observation of such cases? When one considers how many cases of midwifery are attended by so-called midwives, by nurses who have had good training in midwifery, and by general practitioners, it is surely most important that the practitioners at least should have had ample opportunity of learning thoroughly their work in this subject. Another very important feature in this class of work is the management of a miscarriage. Many a valuable life has been sacrificed and many years of suffering and misery brought about by making light of a miscarriage. That terrible scourge of lying-in women—puerperal fever—will surely be relegated ere long to the list of preventable diseases (decomposing lochia bathing the raw surface of some overlooked rent in the perineum, direct contact of the doctor with an infectious case, may be the means of inoculation); absolute antisepsis can alone rid us of this plague-spot in our work. I should like to see established in connection with Guy's Lying-in-Charity a collective investigation on several points in midwifery practice directed by the obstetric physicians, and worked at by past students in general practice. Many of us would be known personally to the directors, and by a little organization I am sure that great and valuable results would be forthcoming. Then, again, how lax are the public generally and we general practitioners over the matter of a lying-in woman getting up; the ninth day is what the old women will tell you; have you ever seen the uterus of a woman who has died about a week or ten days after delivery? How far had the process of

involution gone on? Would a surgeon discharge an amputation of the thigh on the ninth day?—and yet this is what we tacitly do. How many cases of *prolapsus uteri* are due to too early getting about after confinement? Are not we general practitioners to blame somewhat for this?

My own share of midwifery in nine years of general practice has been about 670 cases, and I take this opportunity of saying a few words about one class of women, those who are suffering from anæmia. I have come across a good many, and my experience of them is that they are *bad subjects for parturition;* they soon become exhausted by the pains, they cannot bear an amount of hæmorrhage which to an ordinary woman would be trifling; they cannot safely be left at the usual time after delivery; they are prone to post-partum hæmorrhage. Briefly, whenever you know your future patient to be anæmic, be on your guard. I will not say more on this important subject, midwifery, than to beg of you to set this motto before yourselves in every case, "Absolute cleanliness."

In addition to midwifery, there are two other subjects which are essentially within the province of the general practitioner, I mean the *Diseases of children*, and especially of very young children, under two years of age, and *Diseases of old people.* The former are to be met with chiefly in general practice as to the milder forms of illness, and in more marked stages in special children's hospitals, probably least of all in the wards of a large general hospital. The latter are to be met with largely in general practice, and especially in workhouse infirmaries and poor-law practice, very seldom in a large general hospital. Thus you will see that however much may be done for you here in other subjects, but little can be done in instructing you how to treat the ailments of very young children and infants, or of very old people, unless you seek your material outside the general wards and out-patient rooms. You will find that these two classes of patients have this in common, that they bear sudden and severe illness badly, *e.g.*, a fine baby will in quite a few hours become a perfect wreck from a sharp attack of diarrhœa; and an old man will be at death's door from exhaustion after so simple a cause as an overlong walk. I have repeatedly seen this. You must, therefore, be prepared to deal promptly and correctly with these cases in general practice.

If you continue your habit of observing for yourself and taking notes of your cases and the results of your treatment, you will not fail to notice as years go on how little you knew when first you began to practise. If you happen to be associated with an older practitioner than yourself you will often see him prescribe a line of treatment which you would not have dreamt of, but which his experience has taught him to be right; and in your turn you will do likewise as your experience increases in these two very large classes—the very young and the very old. I ask you earnestly to bear this in mind.

Gentlemen, time will not permit me to dwell upon any other special subjects, but I will ask your indulgence whilst I say something on one or two matters *not* included in the examination schedule, and upon which your examiners will ask you *no* questions. Everyone will agree that true education has to do not only with intellect and intelligence, but with conscience and conduct; that an education which aims at and arrives at nothing more than imparting a certain amount of mental and manual dexterity, or a certain number of useful facts, would be sadly inadequate and incomplete. Principles of conduct are derived largely from the society in which we have been brought up. If that society is healthy, with a high moral and manly tone, we are likely to try and live up to that standard. It is, therefore, the duty of every member of a society like the Medical School of Guy's Hospital, to remember that he no longer belongs to himself, that the honour of the School is in his hands. We may have a very clear conception of our duty, we may be blessed with good surroundings, but unless we show that there is a motive power beyond these we shall fail in our conduct; we are bound to acknowledge a higher power than ourselves. The position of a general practitioner is such that in not a few places his influence for good or evil is far beyond that of any other member of the community in which he lives—a very responsible position—and whether you like it or not, you will not be able to shirk that responsibility. In preparing yourselves for your future work in life, you must make yourselves acquainted with the history of this great Hospital and the lives of the men who have made its name known all over the civilized world. You will find hidden away in the volumes of Guy's Reports, obituary notices of these men, written sometimes whilst their fame was fresh in the minds of men, sometimes not before many of their own generation had passed away. Sixteen years were allowed to come and go before any notice was written of such a great surgeon as John Hilton.

Let us consider what were the features which were common to all in the lives of these masters in their various branches of the profession. I should say (1) their absolute honesty and integrity; (2) their firmness of purpose and capacity for hard work; (3) the business-like way in which they did their work; and lastly, their tender sympathy with suffering and their warm-hearted benevolence. All these traits must be distinctly and clearly marked in the ideal general practitioner. In your training here these *hall-marks of a Guy's man* will be slowly but surely impressed upon you; the material must be malleable, the die must be, and is, well cut, and the press must be, and is, firm and steady. The examinations and the teaching which must lead up to them will call out all your firmness of purpose and your capacity for hard work. Your work in the out-patient rooms and wards will necessitate your work being done in a methodical business-like manner, but for your sympathy with suffering I am afraid the teaching must come from within to a very great extent. There will be times when your work will be very trying. I mean those times when it will be your duty to tell a man that his wife is about

to die, that nothing can save her; when you feel that your words are sapping out of that man's heart all that makes life worth living for; when you have to tell a mother that a child only a few days ill with diphtheria will not recover, as so often is the case. There are ways in which you may say what has to be said so as to soften the blow. Cultivate this sympathy with your patients and you will be better men for the experience. When you have seen the misery which can be brought about by this want of candour or want of courage to say these things, on the part of the doctor, you will know what I mean. I well remember being called some years ago to see a man comatose with diabetes; he had seen some physician, whose name did not transpire, but who had not warned the man's friends that sudden death was not an uncommon termination of diabetes. This patient died without having made a will, the result of which was that his widow was left almost penniless. The case made a great impression upon me at the time, and I only mention it to save some of you from a similar experience. In hospital practice these tender and delicate duties are often relegated to the sisters or the nurses. Do not lose your opportunity, whilst in residence, of performing this unhappy task, so that when you are in practice you may not be a stranger to sympathy with your patients.

There is still another trying duty which must sooner or later fall upon you, and I shall perhaps best explain what I mean if I trouble you with an incident in my own experience. Some time ago I was attending a rich patient who was suffering from influenza with pneumonia; it was evident that he could not recover. After telling his only sister and nearest relation that such was the case, she turned to me with these words: "Does my brother *know* that he is going to die?" I could only reply, "I do not think he does." She at once kindly but firmly said, "Then I think he ought to be told." Gentlemen, I had to tell my patient, and have since been thankful for the experience. I would ask you to think over this possible duty which lies before us.

"Pilocereus Senilis" tells us we have to be, as it were, resting harbours where the broken minds of the sick may refit with every mental strength; and we must be ready to give aid to each shaken faculty; we must be ready to create faith—that greatest of tonics—for the unbelieving; and hope—that best of stimulants—for the despairing; we must find fresh interest for the weary of life.

In order that you may reasonably expect that measure of success in practice for which our Guy's training so well prepares us, it will be necessary that from the very commencement our work should be done in a business-like way, by which I mean that it should be laid out upon a definite plan with a distinct object in view, and with a fixed purpose to attain that object. Any who have read the educational number of the *British Medical Journal* will doubtless remember these words:—"No man whose aim is to make a fortune should dream of entering the medical profession." Now, I do not for a moment suppose that any one ever yet entered or ever will enter it for this reason alone. The article seemed to be despondent and depressing in tone; my sole reason for alluding to it is to allay your fears, for certain it is that a man who qualifies for general practice from Guy's need have no fear as to the means of living—when men fail in general practice, assuming that they know their work, the chief cause of failure would appear to be the entire absence of business-like habits and ways of conducting their practice. In order to warn you of this danger, I would recommend senior men who are anxious to go into general practice, to make themselves well acquainted with the manner of keeping accounts, and such-like business matters, and before starting on your own account, seek the opportunity of seeing the method upon which a large and successful practice is worked. The experience thus gained will be invaluable. Endeavour to act as locum tenens for at least six months, or become assistant in a good practice with a view to partnership in the course of years, and you will be surprised to find how little you know of the business aspect of practice. You will be astonished when I tell you that not a few general practitioners would if asked to write briefly their experience of some of the gentlemen who have come to them as locum tenens say something like this: "Mr. So-and-So is a very nice man, but he cannot dispense, and his knowledge of book-keeping is nil. He regards his patients as cases, and has no interest in them beyond their clinical importance to him. He is rather vague on measles, scarlet fever, and such-like every-day matters." But of course these were not Guy's men. There are some individuals who have sufficient self-confidence to assume that as soon as they are the proud possessor of a qualification they are worth £3 3s. a week as locum tenens, and at least £100 a year, with board and lodging, as assistant. As a matter of fact, they are worth nothing of the sort. I do not think it is fair to a practitioner that any gentleman should be sent by an agent as locum tenens who knows nothing of general practice. When you are in a practice, and that dream of luxury, a holiday, seems to be within the bounds of possibility, you will have to make your estimates on lines somewhat as follows:—(1) What you will spend; (2) what you would have earned if you had been at home; (3) what you will pay your locum; and (4) what your locum may lose for you in your absence if he does not happen to get on with your patients. Sum total—holiday a very expensive affair.

These are things which are not before you at your examinations, but which nevertheless should be items in your education. Do not imagine that the final examination at the Conjoint Board or at the University is the sole object for which you are working; it is but a milestone on your journey through life, hardly a resting place, still less a halt. Many men run away with the idea that when the precious parchment is placed in their hands which gives them, amongst other things, the proud privilege of being exempt from serving in the

Militia or on a jury, there is wrapped up in it all that need be known of all things appertaining to medical education. The hardest examination which we must all face, it may be early at the end of a short life, or late when the length of our days it run, is the judgment of our own conscience.

A distinguished provincial surgeon has very aptly described what the reward of our work is: "the moistened eye and the tremulous grip of the hand, which bespeak thankfulness for the bread-winner restored to the home, the mother to the children, and the child to the parents."

Gentlemen, you will every one of you in general practice reap that reward sooner or later; and your feelings will, in all probability, carry you back to your student days in the Hospital, and to the great debt you and I owe to the Staff of the Hospital. The great characteristic of Guy's teaching has been its *thoroughness*, and the influence of the Staff on the students has been to inspire self-reliance by reason of that thoroughness. General practitioners are the watchmen over the public as regards their health, just as we who live at the sea-side know that the Coast Guards of England, in conjunction with the Medical Officers of Health and their Sanitary Authorities, are the guardians of the country against our much dreaded foe, cholera. It is in the great majority of cases the general practitioner who first sees and watches over and has to decide whether the strangulated hernia is or is not reducible; whether the child with acute abdominal pain has intussusception; whether the intense neuralgia, with pain in the eye, is glaucoma; whether the so-called boil on a man's arm is only a boil or malignant pustule; whether the lump in a woman's breast is malignant or not. I do not claim that he is always right, for I know only too well that this is not so; but it is he who first sees these cases, and who is to a large extent responsible for the subsequent welfare or the reverse of the patient. The standard of proficiency amongst general practitioners is rising every year, and the improvement is largely due to greater facilities which now exist for the teachers knowing the students, and the students knowing each other. Such magnificent organizations as the Guy's *Clubs' Union*, where Staff and students work side by side on the general council, and where each constituent institution has a member of the Staff as its president taking an active personal interest in its welfare, must have one great result, viz., to increase the personal knowledge and regard of the Staff for the students, of the students for the Staff, and to increase the love of both for the School. Bearing in mind how splendidly the rules of the Union have been drawn up, and how admirably they serve the purpose for which they were intended, I feel almost guilty of impertinence in saying just now that you must acquire business-like habits and ways. I was thinking of my own time when we had *no* Clubs' Union, when it was possible for a student to be a staunch Guy's man, working hard, and yet to know very little of the different clubs which belonged to the Hospital. You are to be congratulated on the present prosperous and happy conditions under which you are living, and we older students who are scattered up and down the country in general practice feel very grateful to you for having allowed us to join the Union, and also for our *Gazette*. I can assure you that on the few occasions when the *Gazette* has not reached me at the usual time, I have felt a keen disappointment—have missed something to which I was anxiously looking forward. We are also very grateful to the modest "Pathologist Column," which was the forerunner of the more ambitious Clinical Research Association. There is a real need for such help among practitioners generally, and I am sure the help will be gladly accepted. It is true that in the great medical schools of London we have nothing exactly corresponding to the Unions of Oxford and Cambridge, but have we not, by the established rule of life and work at Guy's, by the strong *esprit de corps* which exists, and by the deep love which we all—present and past students alike—have for our Alma Mater, attained very nearly to the same results? I venture to express an opinion that as a means of education, the mode of life, the work, and the discipline—to a considerable extent self-imposed—a Medical School can turn out men with strength of character second to no University in the world. We at Guy's claim to make men who are medical, and not simply medical men. All our leading public men, from Mr. Gladstone down, are constantly saying that the medical profession is "rising in power and influence and general respect" year by year—that the profession is becoming more powerful and more important as time goes on. We have each to take our share of the responsibility in our own community, and very often the doctor has to take the lead, and the reason why his fellow-men look to him to lead them is because his hospital education has qualified him well for the task. The nation should be proud of the medical schools of England. Gentlemen, one of the rules of the Physical Society, for which you will be thankful when your turn comes, is that no paper shall last longer than thirty minutes. I have already exceeded that time, and only your kindness and sympathy can prevent you from saying you are tired. Much that should have been said on Medical Education has been left unsaid; much has been said which would have been said better by many another; I can only wish that my paper to which you have so patiently and courteously listened had been more worthy of this occasion, this place, and this audience.

Mr. Lockhart Stephens resumed his seat amid loud and sustained applause. Upon silence being restored, Mr. F. G. Hopkins, as an ex-president, moved a vote of thanks to the reader in a thoughtful speech, admirably expressed, and was seconded by Mr. Peters. The vote having been carried with great acclamation, Mr. Lockhart Stephens replied.

A vote of thanks to the Treasurer, proposed by Mr. Stewart, and seconded by Mr. C. J. Harnett, was next

carried, and Mr. Lushington replied in a genial speech, which was much appreciated.

Finally, Mr. A. J. Sharp moved a vote of thanks to Dr. Wilks, and Mr. Moffat seconded, and a hearty ovation was given to the President as he rose to acknowledge that the Physical Society was the real tie which now bound him to Guy's. He wished to thank Mr. Lockhart Stephens for his practical discourse, so full of good sense; the whole purport and moral of it was so excellent. He had never heard a better introductory lecture than the one to which they had just listened from Mr. Lockhart Stephens. What had pleased him, however, more than the address was the man himself, a splendid example of what a Guy's man should be.

During the evening there were on view in the Reading Room of the College, a collection of various articles and objects of interest, amongst which were an "Eclipse" Microscope, lent by Messrs. Ross & Co., 111, New Bond Street; Histological Cabinet from Messrs. C. J. Hewlett and Son, 40, Charlotte Street, E.C.; Photographic Apparatus from Messrs. R. & J. Beck; Books from Mr. Grattan. Various Students' Requisites from Mr. Stanley; a collection of Photographs from Mr. H. E. Durham; an interesting display of drawings and water-colours by Mr. and Mrs. Toogood-Hill; and a general collection of Surgical Instruments from Messrs. Down Bros., and Messrs. Hills & Co.

Notes on Dr. Shaw's Demonstrations in Pathology.

SPINAL CORD AND MEMBRANES.

(*Continued from page 310.*)

Diseases of the Cord.

1. *Hæmorrhage.* The chief feature is the sudden onset of paraplegia; the hæmorrhage may occur in the substance of the cord. Traumatism is a common cause.
2. *Embolism* is as rare as hæmorrhage.
3. *Sclerosis* (1562[82]). This results from lesions cutting off a nerve fibre from its trophic cell; or from a chronic inflammation following an acute.
4. *Growths* may be classified as regards their situation as follows:—
   (*a*) Spine.
   (*b*) Meninges (dura mater or pia mater) (1562[85, 86, 88]).
   May be gummatous, sarcomatous, or carcinomatous.
   (*c*) Cord (1562[25]). The chief feature of the growth is its smallness. Glioma may occasionally be localised.
5. *Syringomyelia* (1562[91, 92, 93]).
6. *Caries of Spine* (1562[72]).
7. *Aneurysm of Aorta*, pressing on cord.
8. *Hydatid* (1562[80]).

Cerebral Meninges.

Inflammation (Pachymeningitis)—

1. *Simple* (1587, 1592[20], 1592[84]).
   Acute pachymeningitis may suppurate so much as to form an abscess, and bony deposit may be a sequel; it is practically equivalent to periostitis of a bone, and you rarely get pachymeningitis without inflammation of the bone.
   Symptoms of middle ear disease have been simulated by extra-dural abscess; chronic inflammation may cause adhesion to either bone or brain.
2. *Tubercle* (1587[25], 1592[51]). The disease is generally disseminated; it is brought by the blood-vessels from other tubercular foci, *e.g.*, caseating mediastinal glands; common in children.
   The pia mater is generally involved as well, but sometimes the dura mater alone is affected and then genefally from local disease, *e.g.*, tubercular disease of temporal bone.
3. *Gummata* (1587[20, 35]), often diagnosed clinically, but not so often found post-mortem.
4. *Adhesion* (1592[56]).

Hæmorrhage.—(*a*) Extra-dural (1593[61]).
(*b*) Intra-dural (1586).

(*a*) Generally due to rupture of an artery (meningeal); may occur without fracture of skull.
Hæmorrhage between the pia mater and dura mater generally results from extension of hæmorrhage beneath pia mater, but may originate from rupture of aneurysm between membranes; also occurs in anthrax, purpura, hæmophilia, and Bright.

Hæmatoma of Dura Mater (1592[10], 1581[80]) may either separate the layers of the dura mater or be beneath it; sometimes consists of recent blood or blood-stained fluid containing crystals of cholesterin; common in G.P.I.

Dura Mater.

Growth.—1. Cancer (1601[15]).
2. Sarcoma (1602[15, 35]).
3. Psammoma (1603[42]).
4. Tubercle (1692[57]).

Most growths within the cranium spring from dura mater. Their limits are very hard to define. They are almost always secondary, but sarcomata, especially fibroid ones, are sometimes primary. Growths are often accompanied by great thinning of bone.

Injury.—Lacerated (1607).
Perforated 1592[60]).

The dura mater is not often lacerated by fracture.

Appointment.

Godson, John H., B.A., M.B., B.C. Cantab., has been appointed Medical Officer and Public Vaccinator for the Cheadle (No. 3) District of the Stockport Union.

A Mummified Child.

The following case may be of interest to some of your readers:—

On August 16th, 1894, the police brought me the remains of a child which had just been discovered in an old woodhouse that was being cleared out. The body, which was perfectly dried and mummified, was that of a male child of full term, and had apparently been placed where it was found immediately after its birth. It had received no attention at birth, for the umbilical cord was several inches in length, and had simply been ruptured and left untied. The weight of the mummy was 9½ ounces. The accompanying photograph will give the best idea of

its condition. Some light-brown hair was attached to the skin over the occiput. The frontal and parietal bones were bare, and the brain had disappeared. All the soft parts of the mouth and chin had gone. The eyeballs were to be seen in a dried and shrivelled state. The skin in front of the thorax was missing, exposing the ends of the left ribs, and showing beneath them the remains of the heart and lungs, the latter resembling small bundles of network. The whole length of the left humerus was exposed in front. Each side of the scrotum had disappeared, only the median raphe being left. The skin in front of the left leg and ankle had given way, exposing the dried structures below. Over the rest of the body the skin was in a fairly well-preserved state and resembled parchment. The abdomen was unopened. The indentation on the right side of the face and neck was caused by a block of wood.

The walls of the house where the body was found were of wood—old, rotten and full of large holes—consequently draughty. The body was laid on the ground, which was sandy, and very dry and dusty; above it was piled a good deal of old worm-eaten wood, so that its surroundings were most favourable for the rapid absorption of all moisture. No offensive smell had ever been noticed.

In this case it was impossible to state whether the child had had a separate existence or not, but from the fact that the body had mummified, the probability is that it had either been born alive (in which case the untied cord might have been a sufficient cause for death afterwards) or had died in birth, as if it had remained dead in utero decomposition would have taken place in a different form. It is strange, however, that a newly-born child should become mummified, as young tissues notoriously decompose fast.

It is a difficult question to determine the length of time required in this country for mummification. Dr. Stevenson, who kindly advised me on the subject, thought that, in this case, taking into consideration the very long dry summer of 1893, and the favourable situation for the process in which the body was found, two years would be ample. There is no certain knowledge that the woodhouse had been cleared out for at least twenty years, but there is a strong suspicion that the body was placed there about three years ago.

Storrington. GEO. H. GRAHAM.

Dropsy and Pregnancy.

The following details may be of some small interest and instruction to some of your readers:—

On September 16th, a lady brought her daughter to see me; she, the daughter, was twenty-six years of age and single, and complained of swelling in the legs and bowels, with great shortness of breath.

For many months past she had suffered greatly from bleeding hæmorrhoids, and three weeks ago she had returned from a private hospital where she had had several of these piles removed by a distinguished operator. She was evidently anæmic, and on showing me her legs I saw that they were very œdematous, pitting deeply on pressure. The aspect of her face suggested chronic Bright, and the symptoms (anasarca, anæmia, breathlessness, legache, etc.) tended to confirm this diagnosis. To make more certain I procured a sample of her urine, and found that it contained about 0·5 albumin, sp. gr. 1033.

From the absence of any other evident cause, I conjectured that it was due to the drain caused by the prolonged hæmorrhage from the bowel. I ordered her to bed, put her on a carefully restricted diet, and prescribed Tinct. Ferri Perchlor.

I should say that there was also a history of more or less amenorrhœa for the last three years—courses generally irregular, with total suppression now for several months.

On the night of September 21st an urgent message came to go at once to the young lady, who was in agonies of pain. I drove off—seven miles—and on arrival found the girl in great pain, as stated; but I noticed that the pain came on at pretty regular intervals and that she was very fairly comfortable between whiles. This roused my suspicions, and I suggested an examination, with the result that I discovered a head presenting, and within half-an-hour a fine boy was in the world. And so the dropsy was cured.

Of course the eminent operator came in for considerable censure for not having discovered this state of things when the girl was under his care in the hospital.

Sherborne. J. REUEL ATKINSON.

Appointments.

The following appointments have been made by the Treasurer:—

House Physicians.—Mr. H. A Duffett (Dr. Pye-Smith); Mr. H. M. Stewart (Dr. Hale White).

House Surgeons.—Mr. E. F. H. Hardenberg (Mr. Howse); Mr. R. H. Fagge (Mr. Davies-Colley).

Assistant House Physicians.—Messrs. L. A. Parry and A. P. Allan.

Assistant House Surgeons.—Messrs. V. Pendred and D. M. Beddoe.

Resident Obstetrics.—Messrs. C. L. Hopkins (October); W. A. L. Smith (November); J. A. Howard (December).

The following appointments have been recommended by the Medical Council, and approved by the Treasurer:—

Clinical Assistants.—Messrs. H. W. Beach, J. C. Constable, J. R. Steinhaeuser, F. S. Brereton, A. Salter, E. T. Shorland.

Dressers in the Eye Wards.—Messrs. J. G. O. H. Lane, R. O. Moon (Mr. Higgens) (November); H. Pern, H. R. T. Fort (Mr. Brailey) (November).

Surgeons' Dressers.—Messrs. R. E. Delbruck, W. L. Stuart, P. N. Vellacott, R. F. Clark, R. H. Ashwin, L. G. Reynolds (Mr. Howse); S. Rivers, C. H. Hunter, F. W. Rowland, C. D. Edwards, O. Beven, W. M. Price (Mr. Davies-Colley); A. P. Beddard, W. C. C. Pakes, C. J. Harnett, P. E. Tresidder, W. S. Handley, H. J. Spon (Mr. Lucas); F. J. H. Cann, J. Hora, B. P. O'Neill, C. B. Statham, A. Scott Turner, W. C. P. Winter (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. H. T. Hicks, J. Howell, C. T. Anderson, A. J. Cleveland, E. J. O'Meara (Mr. Jacobson); D. Rice, N. Lavers, A. M. Rygate, C. Jephcott, J. Ponsonby (Mr. Symonds); W. F. Reckitt, J. N. Gardiner, W. C. Pritchard, H. R. Marsh, C. P. Higgins (Mr. Lane); N. Instone, N. Y. Lower, J. Robertson, E. C. Hort, C. J. Francis (Mr. Dunn).

Medical Ward Clerks.—Messrs. F. W. Ta'Bois, C. H. Fagge, H. P. Ferraby, H. T. S. Bell, A. G. Butler, E. D. Hancock, W. I. Hancock, F. J. Lidderdale, J. B. Parfitt, N. H. Pike, E. N. Scott, A. H. Spicer, M. H. Smith, E. Fisk, W. E. Plummer, S. Whicher, W. R. Wood, G. Burton-Brown, M. C. Hayward, W. E. Hills, H. E. Izard, C. W. Booker, G. E. Duncan, W. J. Henson, C. E. Michael, E. A. Prebble, W. T. Clarke, H. W. Dudgeon, R. Mathias, T. B. Poole, L. T. A. Rowland, H. V. Smith, F. G. Thomas, A. B. Carter, B. B. Gough, C. R. Nicholson.

Assistant Physicians' Clerks.—Messrs. H. S. Desprez, R. T. Brown, T. Davies, P. G. Temple (Dr. Pitt); H. Fulham-Turner, A. H. Finch, J. J. Foster, R. Hedden (Dr. Shaw); E. T. Scowby, W. R. Davies, P. C. Prince, T. J. A. Tulk-Hart (Dr. Washbourn).

Aural Surgeon's Dressers.—Messrs. S. G. Graham, B. B. Ham (November–December).

Dental Surgeons' Dressers.—Messrs. R. F. Clark (October–November); E. R. Fothergill (November–December); G. H. Steele (December–January).

Dressers in the Throat Department.—Messrs. C. E. Carpmael, H. W. Collier, G. H. Field, G. S. Hovenden, R. H. Luce, W. E. Robinson, E. C. Taylor, C. S. Bond.

Post-mortem Clerks.—Messrs. E. E. Henderson, G. B. Muriel (October–November); W. G. Mumford, G. L. Eastes (November–December); C. G. Burton, W. W. Farnfield (December–January).

Obstetric Ward Clerks.—Messrs. R. Henderson, T. W. Stanton, H. Alexander.

Obstetric Out-Patients' Clerks.—Messrs. C. A. Trouncer, P. N. Vellacott, W. Tyson (first half); L. H. Y. Stephen, W. L. B. Davies (second half).

Surgical Ward Clerks.—Messrs. H. Fulton, F. C. Hitchins, H. Leader, E. Moore, V. E. Collins, A. Earnshaw, R. Kay, D. L. Smith, A. J. Wernet, H. Bernard-Onraët, S. C. Clapham, N. F. Clowes, J. Dixon, J. T. Roberts, R. P. Rowlands, E. I. Spriggs, C. P. Weekes, A. E. Porter, R. Howard, W. J. S. Harvey, E. H. Pomeroy, A. T. Falwasser, W. A. Fuller, C. H. Mossop, H. Simson, F. W. Lee.

Assistant Surgeons' Clerks.—Messrs. H. Cardin, A. J. Dolman (Mr. Jacobson); A. H. Bell, E. Ivens Spriggs, J. J. D. Richardson (Mr. Symonds); J. C. G. Reed (Mr. Lane); R. T. Brown (Mr. Dunn).

Clerks in the Electrical Department.—Messrs. C. A. C. Askew (October–November); E. Coleman (November–December).

Clerks in the Skin Department.—Messrs. W. Tyson, T. M. Nicholson.

Externs.—Messrs. O. Beven, C. D. Edwards, C. J. Harnett, F. W. Rowland, W. L. Stuart, M. E. Tresidder.

Clerks to Anæsthetists.—Messrs. A. V. Clarke, E. Coleman, M. P. Jones, B. A. Richmond, H. J. Spon, P. E. Tresidder.

Assistant Demonstrators of Morbid Histology.—Messrs. A. S. Pearse, W. Tyson.

Dental Appointments.

The following Dental Appointments have been recommended by the Dental Committee, and approved by the Treasurer:—

Dental House Surgeon.—Mr. G. N. Willis.

Assistant Dental House Surgeon.—Mr. H. Wallis.

Demonstrators in Conservation Room.—F. C. Beaumont, C. J. Hinchliff, H. D. Mathews.

Assistant Demonstrator of Microscopy.—Mr. J. L. Payne.

Dressers in the Gas Room.—Messrs. H. D. Mathews, A. W. Penrose, J. W. Goddard, H. King, A. F. A. Howe.

Dressers in the Ordinary Extraction Room.—Messrs. F. C. Beaumont, A. Read, B. F. Henry.

Passim.

May we be allowed to add our warm congratulations to those which Mr. Lockhart Stephens has received from other quarters? The success of Monday evening's meeting has been acknowledged on all sides, and for it we think Mr. Lockhart Stephens may fairly take a large share of the credit. Dr. Wilks put the case exactly when he said it was not only the practical words but the man himself which aroused admiration. It was quite apparent to the careful observer that the strong, but sympathetic, nature of the reader of the Paper was surely doing its work on the affections of his audience, even before the remarkable demonstration at the close placed the result beyond doubt.

We are requested to give notice that the Debating Society will meet to-night in the Smoking Room at 7.30, when Mr. A. P. Allan, M.B., will read a paper on "What has become of the Liberals?" after which a general discussion is invited. Dr. Pavy, F.R.S., will preside, and several other members of the Staff have notified their intention of being present.

Mr. Bryant will give a lecture before the Hunterian Society on Wednesday, October 10th, at 8.30 p.m., at the London Institution, Finsbury Circus. All members of the Profession and Guy's Students are invited. Mr. Bryant will deal with certain subjects of Social and Professional interest, which are much under discussion at the present time.

The opening meeting of the session of Guy's Hospital Christian Union will take place on October 11th, Dr. P. H. Pye-Smith, F.R.S., in the chair.

The feelings aroused by the deliverance of a friend from an awful and seemingly inevitable death find but ill expression in words. To Dr. Horrocks we offer a silent but sincere grip of the hand on his miraculous escape from the perils of the Zinal Rothorn.

We are glad to draw attention to the column of "Nursing News," which we hope will in future remain a permanency in our pages. The Treasurer has been pleased to approve of its insertion, and we are also indebted to the Matron, who has kindly promised to provide us "with news of any changes or appointments that are likely to be of general interest." We have undertaken on our part to give a place in our columns to no communications which are not officially approved of by both the Treasurer and the Matron.

We regret to announce the death of Mrs. Turner, widow of the late Treasurer (at the advanced age of 80 years), which occurred on Wednesday last, at the residence of her son-in-law, Mr. Davies-Colley.

All members of the Clubs' Union please note that there is an important alteration this year as regards match cards. The lists of fixtures of both football teams are bound in a small stiff case of convenient size for the pocket. There is a space inside for the owner's signature, and no one will be admitted to the ground on match days unless he produces his match card, which thus is a season ticket. The cards are not transferable, and will be given out by the football secretaries, who will see the owner sign his name, and sign their own underneath.

The Association ground has been enlarged to the minimum Cup-tie limits, and goal nets have been procured. There will be a trial match to-day (Saturday), and, if necessary, one next Wednesday. All who intend to play should hand in their names to the Secretary at once.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	3, 16.	Ulcerative endocarditis.
	17.	Mitral regurgitation.
	19.	Pericarditis. Mitral and aortic.
	31, 48.	Chlorosis.
	44.	Aortic and mitral regurgitation.
	49.	Mitral and tricuspid regurgitation.
Philip	1.	Aortic or mitral regurgitation.
	17.	Dilated aorta.
	19.	Aortic stenosis and regurgitation.
	21.	Mitral incompetence. Adherent pericardium.
	23, 26, 37.	Mitral stenosis and regurgitation.
Stephen	1, 7, 8.	Mitral regurgitation.

Nervous System.

Mary	8.	Hysteria.
	12.	Cerebellar tumour.
	15.	Diphtheritic paralysis.
	21, 47.	Chorea.
	50.	Peripheral neuritis.
Philip	2.	Sciatica.
	3, 7.	Cerebral.
	5.	Peripheral neuritis following malaria.
	11, 13.	Paraplegia.
	15.	Locomotor ataxy.
	20.	Chorea.
Stephen	6.	Hemiplegia following injury.
	12.	Cerebral tumour.
	17.	Paraplegia Myelitis.
	20.	Hemiplegia.
	21.	Peripheral neuritis.

Alimentary System and Diseases of Abdomen.

Mary	46.	Gastric ulcer.
Philip	14.	Dysentery.
	35.	Ascites. Cirrhosis of liver.
	40.	Jaundice.

Genito-Urinary System.

Mary	4, 5.	Chronic tubal nephritis.
	26.	Chronic tubal nephritis. Albuminuric retinitis. Aortic and mitral disease.
	34.	Diabetes mellitus.
	43.	Chronic tubal nephritis. Ascites.
Philip	8.	Acute nephritis.
	10.	Subacute nephritis.
	13.	Diabetes mellitus.
	25.	Chronic nephritis.
	38.	Chronic tubal nephritis.
Stephen	10.	Diabetes mellitus.
	26.	Chronic interstitial nephritis.
	33.	Scarlatinal nephritis.
	38.	Carcinoma of stomach.

Respiratory System.

Mary	27.	Empyema.
Philip	27.	Broncho-pneumonia.
	29, 33.	Pleuritic effusion.
	36.	Bronchitis.
	4.	Bronchitis and emphysema.
Stephen	32.	Peuritic effusion.
	34.	Syphilitic laryngitis.

Phthisis.

Mary 1, 41.
Stephen 16, 28, 30, 35.

Miscellaneous.

Mary	11.	Reynaud's disease.
	21.	Pyrexia innominata.
	25.	Chronic ulcer of leg.
	42.	Perimetritis.
Philip Stephen	32. 29.	Osteo-arthritis.

Typhoid.

Mary 6, 10, 18, 35, 36, 39, 45.
Philip 6, 9, 34.
Stephen 37, 38.

Acute Rheumatism.

Mary 9, 40.
Philip 16, 39.
Stephen 27.

Case under Dr. Pye-Smith.

Mary.

26. M. A. C., æt. 27. Family history good. At age of seven patient had rheumatic fever, followed by seven more attacks, each time relapsing. In March, 1893, she was admitted, under Dr. Taylor, with œdema; her heart impulse was then half-inch internal to the nipple line. At the apex a blowing systolic bruit was heard, traceable to axilla. The œdema became worse, and on April 18th an aortic diastolic bruit was found. Casts were found in the urine. Albuminuric retinitis and optic discs blurred on May 15th, and there was a mid-diastolic bruit. Patient went out much better, and was well till August 7th, 1894, when she was nearly drowned, and had hæmoptysis after resuscitation; in two days she had right pleurisy, the pain having lasted ever since, night sweating, cough and wasting. She now has a puffy face, but no œdema of the legs; a pleuritic rub at the base in right axillary line, cough and bronchitic expectoration; no bacilli found in it. Her impulse is now an inch outside the nipple line. In the pulmonary and aortic areas is a systolic and diastolic to-and-fro bruit, heard best in the pulmonary area. At the apex is a loud systolic, traced out to the axilla; splashing pulse

Albumin and blood are present in the urine; there is no sugar. The inner side of each optic disc is blurred; and in the right eye some spots of abuminuric retinitis may be seen.

Diagnosis.—Chronic tubal nephritis; albuminuric retinitis; chronic endocarditis; aortic and mitral regurgitation.

CASES UNDER DR. GOODHART.

MARY.

14. L. D., æt. 30. Admitted on September 6th, 1894, for headache, vomiting, general wasting and impaired vision.

Family history.—Mother afflicted with paralysis agitans. A brother suffered from fits when quite young, became paralysed in his legs, and died æt. 21.

Personal history.—When 17, patient received a severe shock by the sudden death of a friend. This seemed to affect her eyes, and she had for some time to wear glasses. Has been married for four years, and has three children.

History of present attack.—Began in March, 1894, about two weeks after her third child was born, with pains in her head and face, which lasted for two weeks, and then suddenly one day she fell down, her legs giving way, and became insensible, and on gaining consciousness she was very sick. The next day she had a similar fit, and so on every day until about one month before admission. The only warning she had of the advent of a fit was a slight giddiness, and they occurred in various places. (None of her friends were seen, so that the nature of the fits is only taken from her own account).

She suffered in various other ways, sickness being a very prominent feature, and often lasting for a whole morning. She also wasted very much, and her speech became affected, being slower, and at one time she lost the memory of words. Her eyes were much affected; she often saw double, and always very indistinctly, especially with her right eye. For the month before admission she was at the Albert Home, Bournemouth, where she improved very much, and only had one fit. She also ate well, the sickness having stopped, and her eyesight improved.

On admission.—Patient is a thin woman with dark hair. All her faculties are good.

Sight.—Both pupils react to light and accommodation. No ptosis, strabismus or nystagmus. Ocular movements good, except outward movement of the right eye, which is defective. No diplopia. Vision very indistinct. With the ophthalmoscope there is very definite optic neuritis in both eyes; the edges of the discs are very indistinct and pale. There are some white spots to be seen, and the vessels are intercepted in their course.

Motor functions are defective in the right arm, there being marked inco-ordination. The grip of the right arm is considerably weaker than that of the left. The legs seem normal. Movements of the neck are slow and difficult. No signs of facial paralysis.

Sensory functions.—Tactile sensation is good, also that for heat and cold. No hyperæsthesia.

Reflexes.—Plantar reflexes are slightly exaggerated. Knee-jerks brisk. Ankle-clonus is present. Elbow-jerk present.

Speech.—Slow, but accurate.

Smell.—Normal.

Hearing.—Slight deafness of right ear, but hears well by conduction through the mastoid process.

Taste is absent on the right side.

Diagnosis.—Cerebral tumour, probably left side.

Treatment.—Liq. Hyd. Perch. ʒi.
Pot. Iod. gr. v.
Mist. Pot. Iod. ad. ʒi. t.d.s.

Progress.—Her eyesight improved slightly, also the movements of her right arm, the grip of which became nearly equal to that of the left. She was occasionally sick.

On September 17th, while sitting up in bed to reach a jug, she fell back on the pillow in a faint, but does not know how long she remained unconscious. On recovering she had a severe attack of vomiting, and lost power in her right arm and leg, and also the power of speech. During the day the pains in her head were very bad.

18th. The headache had gone, but was very bad on the night of the 20th. On the 21st she had a severe attack of vomiting, and was ordered Pot. Iodi. ♏ ii. On the 24th, pain in the head still very bad. In the morning she had another fainting fit, which was preceded by trembling of both the left and right arm, especially the left. The conjunctiva reflex was lost, and saliva ran from the mouth. She was unconscious for about one minute. Both eyes were turned to the left.

25th. Patient was excessively weak, and fainted two or three times.

27th. Was much better, and had no pain.

29th. In the evening patient had another fit, which left her very weak.

30th. Still very weak; became comatose, and died in the afternoon.

At the autopsy.—There was a small circular mass of growth about three-quarters of an inch in diameter on the inner surface of the dura mater, pressing on the lower and outer surface of the left side of the cerebellum and indenting its surface; also an irregular mass occupying the front part of the right lobe of the cerebellum, and pressing directly on the right side of the medulla, and a small nodule in front of corpora quadrigemina between the optic thalami, near their inner surface. There were secondary nodules in the dura mater. The ventricles contained some fluid.

24. E. P., æt. 65. Admitted September 4th, 1894, for pain in chest and difficulty in swallowing.

Personal history.—Patient has had sciatica and pleurisy; married; has a son and daughter, and has had two miscarriages.

History of present illness.—About ten months ago patient began to get attacks of pain, which was dull and aching in character, extending from the root of the neck to the lower end of the sternum. They come on

gradually, are brought on by eating solid food, or by exertion, and cease soon after the food has passed, or in the latter case when patient rests.

Condition on admission.—Patient is thin from having eaten very little lately. There is a slight lateral curvature of the spine.

Circulatory system.—Heart is acting very irregularly; dulness normal; impulse strong and slightly diffused in fourth space one inch inside nipple line. There is a localized blowing systolic bruit heard over impulse, and another rather better marked, also systolic, over the base, best heard to the right of sternum. There is an elongated pulsating swelling commencing under the origin of the right sterno-mastoid muscle, and extending along the top of the sternum over the front of the trachea, on the left side of which it terminates. The pulses, radial and carotid, are equal.

Respiratory system.—Chest narrow; lungs, deficient entry of air into right chest behind, below angle of scapula.

Urine.—Sp. gr. 1023; acid. No albumin.

Treatment.—Mist. Pot. Iod. ʒj., 6tis horis.

Progress.—In a few days patient could eat without pain.

Dr. Goodhart thought the swelling was an abnormally placed vessel, as it did not feel like an aneurysm, and also he could get his finger below it; and that the swelling in the neck was not the cause of the difficulty in swallowing.

PHILIP.

4. W. S., æt. 30, carman. Admitted September 14th, 1894, for diarrhœa, loss of appetite and pain in abdomen.

Personal history.—Patient had never been strong. Suffered from a cough for the last eight years.

History of illness.—Has had diarrhœa for four or five weeks, and therefore has eaten very little.

On September 5th had pain in his abdomen and worse diarrhœa; also had head and backache.

On September 8th he vomited up one or two cupfuls of blood, and had such violent retching that there was effusion of blood into his eye-lid and his nose bled.

On September 12th he again vomited up blood—three-quarters of a chamberful. He was treated by his own doctor, who diagnosed typhoid fever.

For the last week he has suffered from pains in his head, and has wandered in his talk. There have been considerable twitching movements when asleep. On the day of admission he passed eight brownish, watery stools.

On admission.—Patient was anæmic, feeble, and collapsed. Temperature 102–4. Pulse 87. Respiration 27. There was effusion of blood into right conjunctiva, reaching into outer canthus, and also into both upper lids.

Alimentary system.—Tongue fairly clean; slight white fur on middle and back. Complained of pain transversely across umbilicus. There was no tenderness over cæcum. Neither spleen nor liver could be felt. Splenic dulness normal. On the abdomen there were six fairly typical typhoid spots; also two on front and four on back of chest.

Circulatory system.—Pulse full, soft, and regular. Heart not displaced; cardiac dulness diminished. At the apex a rumbling systolic bruit following first sound, traceable half-way across the axilla; second sound loud. Also a systolic bruit over aortic area.

Urine.—Sp. gr. 1024; acid. No albumin or sugar. Did not give a satisfactory Ehrlich's reaction. There was a large amount of indican present.

Treatment.—Hot flannels to abdomen.

Tr. Opiatus } aa ʒi. t.d.s.
Tr. Belladon }

Progress.—September 15th. Patient very feeble and drowsy; diarrhœa profuse. A large clot, 1 by 2 inches, passed per rectum. The stools also contained a little blood. No sloughs observed. Twitching marked. Was given Tr. Opii ɱ vi.
Aq. ad ʒ ss. 4tis horis.

17th. Patient was sweating profusely. Vomited twice in morning. Was ordered Pil. Plumb. c. Opio, gr. iii., 4tis horis, and a mixture of white of egg, barley water, and lemon juice.

18th. Diarrhœa continues, and motions contain blood. Patient slightly delirious. Temperature from 102–103. The pill omitted; and

Tr. Opii ɱ vii.
Mist. Cret. ad ʒi. 4tis horis.

and Brandy ʒi. given.

The pupils were too contracted by the opium to be examined.

21st. A very large amount of blood in motions, not black; quantity, one or two pints. Pulse feeble.

Hæmostatics were given as follows:—Enema Acid Tannic; Enema Amyli c. Opio; Ergot gr. i. injected. No stimulants.

22nd. Diarrhœa less, also less blood; hæmostatic treatment continued.

23rd. Diarrhœa worse, but no blood. Champagne ʒviii. ordered.

25th. Patient very weak, pulse very feeble. He did not respond to stimulants. Mosch. gr. v. and Brandy ʒviii. given.

26th. Patient very weak and almost pulseless; was ordered Brandy ʒviii. and Mosch. gr. v., but did not pick up. Temperature, at 6 p.m., 103·2. Died at 10 p.m.

At the autopsy.—There was local peritonitis, the small intestine was adherent to the transverse colon, and the omentum was bound down to the intestines. The sigmoid had perforated opposite the inner fourth of Poupart's ligament, and was adherent to the abdominal wall.

Larynx.—Ulcers on both sides of the epiglottis, half-inch long, and exposing the cartilage; small ulcer on posterior part of right vocal cord.

Lungs.—Left, emphysematous; both œdematous.

Heart.—Ten and a half ounces; great thickening of aortic valves.

Spleen.—Eleven ounces.

Kidneys.—Normal.

Stomach.—Cardiac end congested.

Intestines.—Acute and very profuse ulceration of the whole of the large intestine. The ulcers had a punched out appearance, and in many cases the base consisted only of peritoneum. The small intestine was ulcerated for four and a half feet above the ileo-cæcal valve, some of which had sloughs attached. There were no signs of any heating ulcers.

Dr. Goodhart would not at once diagnose typhoid fever, but proposed first to watch the case. He pointed out that the history was peculiar in many points for a typhoid history, and that the case rather suggested a scorbutic or purpuric condition.

Dr. Shaw also saw the case, and in discussing the diagnosis, said, that besides enteric fever, malignant endocarditis had to be thought of, the two diseases resembling each other so very closely, he was inclined, however, to think that it was a case of typhoid, which was confirmed at the autopsy.

11. F. W., æt. 34, employed in Woolwich Arsenal. Admitted on September 26, for inability to walk. Had been in the Army, and was invalided home from India in 1881 with Bright's disease. On March 19th he slipped off a travelling crane and fell forty-three feet. He has never been able to walk since the accident. For three months he could not pass his urine without using a catheter. He suffered from pain in the back and girdle pain.

On admission.—There is prominence of the lower four dorsal vertebræ, and some pain in this region. There is loss of power in both legs, and the left arm. Great wasting of muscles of left forearm and hand; and impaired movement of joints of left hand. Knee-jerks are present. The feet are fixed in a position of over extension; marked loss of sensation on outer side of left leg and foot. There has been constipation since the accident.

Diagnosis.—? Fracture; dislocation and compression; paraplegia.

13. R. S., æt. 42, a coal porter. Admitted September 14th for an injury to the back. About five weeks before admission he had slipped when lifting a sack of coals, and the loaded sack had struck him on the back. He continued to do his work for a fortnight, and was then obliged to give up on account of weakness in his legs. This weakness increased, so that on admission he was unable to walk. He suffered from girdle pain, running round the body to the umbilicus. For a fortnight after the accident he was unable to retain his urine for any length of time; he also had constipation.

On admission. — There was great pain over lower lumbar and sacral regions, the pain running round the body; there was considerable hyperæsthesia in these regions. No loss of sensation. Knee-jerks present. Pupils react to light and accommodation; optic discs normal. The girdle pain gradually passed off. The legs became stronger, and patient is now able to walk.

September 28th. There is tenderness over the ulnar and musculo-spiral nerves, with some tendency to dropped wrist.

Diagnosis.—? Spinal meningeal hæmorrhage.

19. J. F., æt. 47. Admitted 11th September, 1894, for pain in chest and weakness.

Personal history.—He is a deep-sea fisherman, and his work is hard. Married, and has six healthy children. Has never had venereal disease. Has been a total abstainer seventeen years, and was temperate before that.

History of present illness.—Two years ago patient had influenza, and went to sea immediately after, while feeling very weak. He soon began to have pains in his chest on attempting heavy work; the pains gradually got worse till he could do no work at all. Sometimes they were so severe as to cause him to fall. The pain begins at the lower end of the sternum, and spreads up to his throat, and when severe, extends all over his chest and down both arms. It is a feeling of great oppression, accompanied by faintness. He says it is as though his chest were being forcibly distended. He then passes flatus by the mouth, and on lying down feels better. During April, May and June, 1894, he was in Lowestoft Infirmary, but was not benefited. Since then he has had pains in the heels and tendo Achillis of both legs, and the soles of his feet swell when he walks. His ankles have never swollen.

Condition on admission.—Pulse 94; temperature 98; respiration 20. Patient is neurotic, and gets excited when examined, his pulse sometimes running up to 120. There are stigmata, and pigmented stains of old ones on the front and back of the trunk.

Circulatory system.—Cardiac dulness large, increased downwards and to the left. Impulse strong and heaving, slightly diffused in the sixth space, one inch outside nipple line. There is a diastolic bruit, well-marked and blowing, heard best in aortic area, and widely diffused. There is a softer blowing systolic bruit over the base, also widely diffused; and there is a long diastolic rumbling bruit which begins early. Pulse 94; strong and full, with a not very well-marked splash. Arteries slightly thickened. Capillary pulse obtained on pressing forehead. Sphygmographic tracing showed too high tension to be typically aortic. No increased pulsation in the neck. Tenderness on pressure over the præcordial area, and particularly over lower end of sternum.

Lungs.—Normal.

Urine.—Sp. gr., 1020, acid. No albumin.

There is a hard nodular tumour one inch each way just below right great trochanter, movable on parts below, not involving the skin. It has been there for two years, and has not grown lately.

Diagnosis.—Aortic regurgitation and angina pectoris.

Treatment.—Liq. Strychninæ Hydrochlor ℥iij.
Liq. Nitroglycerini ... ... ℥j.
Mist. Ferri et Quassiæ ad ʒi.

Character of pain and aspect of patient point to angina pectoris, the aortic regurgitation being sufficient to account for it. The aortic systolic bruit indicates little or no obstruction, not being accompanied by thrill or small pulse. The aorta near the heart is probably

diseased, the upper part being healthy, as shown by absence of pulsation at top of sternum.

In the Surgical Wards.

Cases under Mr. Howse.

Accident	9.	Injury to loin. Hæmaturia.
	14.	Fractured neck of femur.
	17.	Fractured skull. Scalp wound.
	26.	Stab in chest. Emphysema.
	30.	Concussion.
	32.	Compound fracture of skull. Fractured ribs.
Naaman	1.	Ulnar nerve cut at elbow.
	14.	Hæmorrhoids. Prolapsus ani.
Charity	—.	Lipoma over shoulder.
	15.	Lacerated wound of arm.
	20.	Axillary abscess.

Cases under Mr. Lucas.

Lydia	12.	Congenital webbing of fingers.
Job	5.	Gangrene of toes following crush, with extensive swelling of foot and leg. Removal of gangrenous portion. Treatment with sulphur. Clean granulating surface.
	6.	Enlargement of upper end of tibia. ? Chronic abscess in shaft of tibia.
	17.	Small growth or mole.
	21.	Ankylosis of knee. Healed tubercular joint.
Charity	4.	Carcinoma mammæ.
	5.	Carcinoma mammæ.
	17.	Carcinoma mammæ.

Cases under Mr. Golding-Bird.

Lazarus	4.	Tubercular hip.
	8.	Spinal caries.
	8.	Popliteal aneurysm.
	13.	Secondary syphilis. Nodes on clavicles and over skull.
	22.	Appendicitis.

Cases under Mr. Lane.

Job	12.	Headache and incapacity for work, following concussion.
	14.	Hæmorrhoids and prolapsus ani.

Nursing News.

List of Probationers and Lady Pupils who have passed the Examinations on Medical Nursing, September, 1894.

Attwell.	Davis.	Hughes.	Skerman.
De Bulmer.	Douglas, E.	Lawrence.	Stowell.
Brown, S.	Davidson, A.	Leng.	Timbrell.
Baylis.	Davidson, M.	Löhmann.	Taylor.
Bell.	Freeman.	Miller.	Tillott.
Clarke, S.	Firth.	Merritt.	Woodward.
Creighton.	Garland.	Nicholls.	Wilks.
Coupland.	Grange.	Pearson.	Willcox.
Chippendall.	Huck.	Press.	Wiltshire.
Coombs.	Hobhouse.	Pooley.	Wilson.
Chester.	Hyland.	Powell.	
Dupuis.	Homfrey.	Raynes.	

Reviews.

Descriptive Catalogue of the Pathological Specimens contained in the Museum of Guy's Hospital. Third edition. Vol. I. By Lauriston E. Shaw, M.D., F.R.C.P., and E. Cooper Perry, M.A., M.D., F.R.C.P. (J. & A. Churchill).

Vol. I. of this Catalogue, the latest edition to the literature of Guy's Hospital, will be received with great satisfaction. In a concise preface information is afforded of the early printed catalogues, the first of which was edited by Dr. Hodgkin, and published in 1829; the second, which appeared from 1857 to 1863, being the conjoint work of Dr. Wilks and the late Dr. Habershon. The present volume is the first of the third edition, of which three, if not four, separate volumes are to be published. The work of the editors has been thorough, as its result conclusively shows—"the greater number of the preparations have been submitted to further examination and dissection before being remounted, and the descriptions given of them have almost in every case been re-written upon a uniform plan," which, it may be added, will be found most acceptable and convenient to students when using the Museum. Not only have references in every case been verified, but what perhaps makes the Catalogue of the greatest value, clinical accounts of the actual cases have been added to the descriptions of the specimens, and where already given in the old Catalogue have also been revised and amplified.

Volume I. is devoted to the "Morbid conditions of the Respiratory Organs and Alimentary Tract"; it is divided into twenty-four sections, dealing with a description of 1,245 specimens, tabulated in a table of contents, on reference to which what is wanted can be readily found. The "uniform" arrangement adopted by Drs. Shaw and Perry in the compilation of their work is a simple and excellent one. For example, Section I. deals with "Injuries and Diseases of the Larynx," and occupies 28 pages. The specimens, which amount to 89, are numbered and arranged according to a definite system. Congenital malformations and irregularities are first dealt with, then injuries and foreign bodies; next on the list are the morbid conditions of the organ itself, such as œdema, ulceration, etc.; the description of these specimens is followed by the conditions of the organ met with in special diseases—*e.g.*, Syphilis, Lupus, Variola, Typhoid, etc. Growths of the larynx are next represented, beginning with the simple and concluding with the malignant forms. Again, in Section XIII., this plan is quite as successfully adopted; firstly, in regard to the tonsils, then to the palate; and lastly, in regard to the fauces. In short, too much cannot be said in praise of the universal arrangement which the editors have conceived, and which has met with such conspicuous success. That it will materially aid the student in his studies in the Pathological Museum there can be no question of doubt. Not merely will valuable time be

saved, or in other words, will more work be able to be done in a shorter time, but the useful habit of associating the morbid conditions of the organs of the body in the same "chronological order" will be more firmly impressed upon the mind of the reader. As to the description given to each specimen, the following illustration, from "Section XVI., Injuries and Diseases of the Stomach," will serve as an index to the manner in which the editors have performed their arduous task:—

"596. Gastrostomy.

"A portion of the abdominal wall with some of the costal cartilages from the left hypochondriacal region showing, at the upper part of the linea semilunaris, an incision, to the margin of which is attached a part of the anterior wall of the stomach," etc.

"Walter H., æt. 47, was admitted under Dr. Habershon with urgent dyspnœa, which was treated by tracheotomy, with slight relief. Subsequently he became unable to swallow food, and Mr. Cooper Foster performed the operation of gastrostomy. . . It is believed that this was the first time that this operation was performed in England," etc.

"See Insp. 1858, No. 64; and Guy's Hosp. Reps. 1858, p. 1."

With regard to the references, there is a noticeable omission, which is perhaps not of paramount importance to many who will use the Catalogue. It is, that the editors have given no explanation of the abbreviations they have rightly made use of in this respect. References such as "Guy's Hosp. Reps.," "Trans. Path. Soc.," and "Trans. Clin. Soc." are perfectly obvious. "Insp. 1858, No. 64," conveys no meaning to the average reader; nor is "Drawing, No. 317," much more intelligible. This is a defect, however, which the editors will doubtless rectify in Volume II.

We noticed also that the numbers attached to the bottles containing specimens 33 and 34 have by mischance been transposed. In a work of such magnitude it is, however, a matter of congratulation that so few mistakes have occurred; in fact, so far as printer's errors are concerned, there appear to be none. The volume, beyond being a little heavy for the hand, is well got up and produced by the publishers.

Every Guy's man—especially the senior student—will feel the great boon that Drs. Shaw and Perry have conferred on them, as well as on the Medical School, by the production of this volume, the more so as their labours have been entirely voluntary. Its greatest value, to our minds, lies in the aid it will afford to the study of Pathology at this Hospital. For the convenience of students some copies of the Catalogue, printed for use in the Museum alone, are to be published separately in smaller parts. E.

Hydatid Disease. Vol. II. By the late John Davies Thomas, M.D., F.R.C.S. Edited and arranged by Alfred Austin Lendon, M.D. (Bruck, Sydney, N.S.W.; Ballière, Tindall & Cox, London).

This work which—nearly completed by Dr. Thomas before his death—is now issued by his friend and former partner, Dr. Lendon, of Adelaide, deals in a most exhaustive manner with hydatid disease affecting almost every part of the body. It is divided into four parts, styled Volume II., and contains much valuable information on a subject the pursuit of which Dr. Thomas's vast experience on the Australian continent has enabled him to speak with authority. Part I., occupying thirty-four pages, deals with hydatid disease affecting the abdominal organs—the liver, spleen, kidney, peritoneum, male pelvis, testicle and female pelvis. Part II. treats of hydatid disease of the thoracic viscera—the lungs and pleuræ, the heart and great blood vessels. Part III., of the nervous system—the brain and its membranes, and the spinal cord; and part IV., of the bones, muscles, and superficial structures—the bones and joints, the muscles and fascia, and the breast. In Part V., the reader is treated to an excellently-written treatise on the operative treatment of the disease.

In the general arrangement of the papers, the editor has done his work well. In the description of the disease met with in every organ the same plan has been adopted. Its frequency, its site, the symptoms and physical signs, all are adequately and intelligently described. Displacement and compression of adjacent structures and rupture of the cyst receive an amount of consideration which must have formed no small part of the author's assiduous labours. References are given by dozens on almost every page, yet the clinical accounts never become wearisome nor seem too full; the book, written by a student for a student, will be found an acceptable addition to the literature of hydatid disease, and should become the student's and general practitioner's standard work on the subject. At the beginning of each part there is given an extensive Bibliography—judging from which one may be able to estimate the thoroughness and exactitude with which Dr. Thomas carried out his researches. It is a matter for regret that the editor has neglected to furnish the readers of his friend's work with an index as well as with a table of contents. The volume itself, though containing such a vast amount of information—especially valuable in the clinical aspect of the disease—is a handy-sized one of 166 pages. There is also a somewhat laudatory memoir of the late Dr. Thomas, which is perhaps of more immediate interest to his many friends and admirers. S.

Volunteer Mess.

Different branches of the Volunteer force are represented at Guy's, and it has been proposed to hold a united mess supper, followed by a smoking concert. The movement so far has not gone beyond its proposal, but a meeting will be held on Tuesday, October 9th, at 1 p.m., in the Surgical Class-room, to discuss possible arrangements. Every Volunteer is requested to attend this meeting, in order that the general feeling on the subject may be arrived at.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra amount of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps which have been sterilised by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

B., Paramatta, Australia.—The material forwarded is of vegetable nature, and is part of a fruit.

W. H. M., Kidderminster.—A few bacilli were observed in sections of the inflamed ulcer. These were stained by Gram's method, and are probably tetanus bacilli. Absolute identity, however, can only be established by examination of the fresh pus or scraping.

T. J. M., Huddersfield.—(A) is a mass of fibrin in which are embedded plasma cells. No malignant or tuberculous structure was recognised. (B) The epidermis scraping shows an increased activity of the lower layers of the Malpighian zone, and some slight infiltration of the subcutaneous tissue.

W., Middlesborough.—Urine, sp. gr. 1008, acid. A trace of albumin was found. Amorphous urates are present, but no casts.

S., Walthamstow.—Klebs Löeffler bacilli are present in quantity.

F. M. C., Devonshire.—The testicle is enlarged by a fibrous new growth which is caseous in the centre. It is a caseous gumma.

W., Gravesend.—The growth is an epithelioma which is infiltrating and causing a great deal of irritation. There is little ulceration.

A. C. B., Dorking.—No tubercle bacilli were found in sputum.

G. F. H., Balham.—In sputum labelled 2, tubercle bacilli are present in quantity. In specimens 1, 3 and 4, none were found.

PATHOLOGIST.

Ahem!—Successful M.D. to non-successful M.D.—"I had to turn out of bed three times last night." Non-successful M.D.—"Why in the name of all that's sensible, don't you buy some insect powder?"

Sport.

Guy's Hospital Rugby Football Club.

The trial match of the above Club was played on Wednesday, 3rd October, when thirty members turned out, fourteen of whom were new men. A very good game was witnessed, the Whites, captained by N. H. Pike, winning by two goals two tries (tries by Barrow, Gardiner, Pike and Wetherell, goals by Gardiner), to two tries (by Edwards and Hunter).

Among the new three-quarters, Rae, Ramsford, and A. H. Bell, seemed to be about the pick. Rae showed a fair amount of pace, but must learn to use it more; he waits for his centre too much from a desire to pass back to him; he must also collar lower. Ramsford and Bell both showed a fair knowledge of the game and tackled well. R. S. Thorpe was the only new half-back that turned out; he should be an addition to the team, fielding and kicking well, but must get out of the habit of passing over his near three-quarter's head, as it would be most dangerous for an intercept. Of the new forwards, Wood, Gardiner and Hunter were the best, and in all probability the three will be given a trial. Of the old men, Wetherell was the best three-quarter on the ground. Barrow showed very good form and must be looked after, as with a little teaching he promises to be a very fair wing. Dykes would be a good forward if he got into training. The teams were:—

Stripes.—H. Walling (back); J. B. C. Brockwell, A. C. Ramsford,* A. H. Bell, C. N. Doyle, (three-quarter); G. K. Kevern, W. S. Stewart (half); W. Tyson (capt.), C. D. Edwards, M. D. Wood, H. H. M. Saward, P. D. Hunter, E. G. Goddard, A. E. Porter, C. H. Fagge, N. Denham (forwards).

Whites.—P. F. Henry† (back); H. P. W. Barrow, C. B. Dowsett, W. Wetherell,* F. L. Rae (three-quarter); R. S. Thorpe, A. E. Maturin† (half); N. H. Pike (capt.), J. N. Gardiner, P. A. Dykes, E. D. Gardiner, C. Jephcott, J. J. Foster, A. H. Carter (forwards).

United Hospitals' Cycling Association.

The first Inter-Hospital Race Meeting was held on September 28th, for the valuable Challenge Shield presented to the Association by G. Mellin, Esq. The track at Herne Hill, belonging to the London County Athletic Club, had been wisely selected for the occasion. By the rules of the Association, each affiliated hospital was permitted to enter three representatives for each of the races. The distances were respectively one, three, and twenty miles, thus affording full scope for the display of sprinting and staying powers. Thirteen competitors had entered their names from four of the London Medical Schools, of whom six came from Guy's, three

*Ramsford and Wetherell changed before half-time.
†Henry and Maturin changed at half-time.

from London, and two from St. Thomas's and University respectively. All save one faced the starter.

There was a very fair muster of spectators present, many of whom belonged to the fair sex. Amongst them we noticed Mr. Golding-Bird, who is President of the Association, Mr. and Mrs. Arbuthnot Lane, Rev. J. H. Smith, J. J. Pilley, Esq., — Rowley, Esq., and others. The afternoon, though chilly, was all that could be desired for speed, and the racing was throughout distinctly above the average, and some excellent times were clocked. The twenty miles' race called forth an exhibition of some of the pluckiest riding we have ever had the pleasure of witnessing, and the time recorded was only four minutes outside world's record for the same distance. The two heroes of the day were Mr. A. F. Millar, of St. Thomas's, and Mr. H. J. Millbank-Smith, of Guy's, the race between whom in the twenty miles was productive of a scene of intense excitement and enthusiasm. Pace-makers were allowed, and a speedy tandem ridden by Messrs. Polehampton and Broadbridge, of the London County Athletic Club, was responsible for the largest share of the pacing. To them all thanks are due for the ultimate success and popular win of Mr. Millbank-Smith. He and Mr. Millar, paced by the tandem, hung together for the first eight miles, when Millar, calling for more pace, went off at a terrific rate, and for the time Millbank-Smith was left to make his own going, nearly half a lap behind the St. Thomas's man. A pacemaker was, however, soon found for him, and the tandem just then taking a rest, the two leaders maintained their respective positions for some three miles, though the Guyite was gradually gaining ground each lap. At the fourteenth mile, the tandem again started pacing Millbank-Smith, who had been reserving himself for some time past. Hanging on behind the couple, he made up his lost ground every lap, and between the fifteenth and sixteenth miles was level with Millar. By this time the latter was looking rather baked, and evidently hung on at the expense of his remaining energy, which had been severely tested in the one and three mile races, of which he was the winner. At the eighteenth mile, Millbank-Smith was heard calling for more pace, and amidst intense excitement, gradually forged ahead of his opponent, who was now evidently "done." Riding with great dash and much judgment, the Guyite increased his lead in each of the succeeding seven rounds, and though Millar made one last effort when about two laps from the finish, Millbank-Smith secured a popular victory by 300 yards, or about three-quarters of a lap. An unfortunate mistake occurred in the one mile final heat; as the men, all bunched together, passed the group collected at the winning point, they were told "two more laps to go," and it was not till nearly half a lap had been covered that the error was perceived, and the bell, signifying "last lap," was rung; our Guyite was hemmed in and could not get fairly off; Millar was leading and went away, leaving the crowd to fight out the race for second and third positions. It is possible that, but for this, Millbank-Smith might have secured second place, instead of third, and thus added one more to the points Guy's eventually scored. Had this been the case, we should have tied with St. Thomas's, for we were only defeated by one point. The system upon which points for the Challenge Shield were scored was as follows:—In each race first place counted three points; second place, two; and third place, one. The prizes, which were handsome and useful, were graciously presented to the first and second in each race by Mrs. Arbuthnot Lane at the conclusion of the twenty miles race. A prize fund had been raised, to which the following gentlemen had generously contributed: Messrs. Golding-Bird, Victor Horsley, A. H. Tubby, J. H. Oppenshaw, J. W. Washbourn, and Messrs. Maw, Son and Thompson.

Mr. Golding-Bird made a happy and most appropriate speech, in the course of which, after gracefully alluding to the generosity of Mr. Mellin in presenting a challenge shield of such great beauty and intrinsic value to the Association, he spoke of the present occasion as one of general interest, in that it created a precedent, and tended to weld in one the already numerous bonds of good feeling existing between the medical schools of the metropolis. After referring to the plucky riding of Mr. Millbank-Smith in the long race, he went on to say that being a Guy's man he might fairly say he represented the general feeling of Guyites in regarding their sister hospital with envy, but in no jealous spirit, and that he heartily congratulated the victorious team on the magnificent display of racing which had been afforded during the afternoon.

The meeting was closed with a hearty vote of thanks to Mrs. Lane and cheers for Mr. Golding-Bird. Appended are the particulars of the racing.

The mile was ridden in heats, but only in the final heat were the points taken into account. The leading officials were as follows: Starter, Mr. H. A. Munro (L.A.C.); timekeeper, Mr. J. Dring (London County); judges, the committee. Result:

One Mile Scratch Race.—Heat 1: H. J. Millbank-Smith, Guy's, 1; R. L. Head, St. Thomas's, 2; A. S. Bruszaud, London, 3; A. Wood, Guy's, 0. Won by ten yards. Time, 2 min. 36⅗ sec. Heat 2: A. F. Millar, St. Thomas's, 1; E. A. Longhurst, Guy's, 2; E. T. Inkson, University, 3; L. T. R. Hutchinson, London, 0. Won by twelve yards. Time, 2 min. 40 sec. Final heat: Millar, St. Thomas's (3 points), 1; Bruszaud, London (2 points), 2; Millbank-Smith, Guy's (1 point), 3. Won by ten yards, five yards between second and third. Time, 2 min. 55⅕ sec.

Three Miles Scratch Race.—A. F. Millar, St. Thomas's (3 points), 1; H. J. Millbank-Smith, Guy's (2 points), 2; W. G. Noble, London (1 point), 3. Also rode: E. A. Longhurst, Guy's; R. L. Head, St. Thomas's; and C. Reed, Guy's. Reed had a spill. All were together when the bell rang, but Millar then sprinted away, and won by fifteen yards; ten yards between second and third. Time, 8 min. 32⅖ sec.

Twenty Miles Scratch Race.—H. J. Millbank-Smith, Guy's (3 points), 1; A. F. Millar, St. Thomas's (2 points),

2; A. Woods, Guy's (1 point), 3. Also rode: W. G. Noble, London; A. S. Bruszaud, London; L. T. R. Hutchinson, London; and C. M. Beadnell, Guy's.

The winner's time was 50 min. 37⅘ sec., and Millar's 51 min. 2⅘ sec. Woods hung on for some distance behind the leading men, but fell behind after the first few miles, and though paced at intervals during the race, had to make his own going for some miles; his performance is therefore very creditable. A. Schäfer, Esq., helped Millar by pacing him when not going behind the tandem. The total scores were St. Thomas's, 8; Guy's, 7; London, 3; University, 0. It is intended to make this an annual event.

A fifty mile road race is in contemplation, to be held at the end of this month. Intending competitors are requested to send in their names early to the secretary, C. Reed.

Guy's Hospital Bicycle Club.

Invitation Club Run to Meopham, Kent.

"Fair: local showers," said the weather prophet. Our club run just stumbled on that locality. The club convened at Lee Green—in part, for our own (we had nearly said, our only) scorchers missed the gathering at Lee Green, and foregathered at Meopham by the northern route. The machines of most of the party evinced a strong desire to sit down on the greasy setts of the Old Kent Road; but all went well when, through Foot's Cray we struck terra firma (though only by comparison). And there were present the up-to-date racer, the air-bound semi-racer, the solid roadster, ye anciente crocke, and the abortion; but all cracked along merrily enough to Swanley, when one of the brothers must needs nail his tyre to his rim, whereby he perforated, and the other waited for the completion of the plastic operation. It was here, too, that some developed alarming symptoms of polydipsia. Then came the wild race for the top of the Kentish Weald, wherein the racer outstripped them all, and the abortion and the ancient crock, *proxime accessunt*, left all else in their mad career down into Wrotham, and the rain descended, and the mud ascended, and fore and aft were those three sore wet, while a broad ever-deepening track of mud evolved itself on the back of him who bestrode that abortion. Then up the Wye hill with painful steps and slow, breathing out curses deep and low, against the elements; till, just over the brow, another wild burst, and there was our President, on the latest of airy, fairy, three-wheels from Coventry. Acting as guide, he escorted us to his *maison á la campagne*, where all who needed it were dry clothed, efficiently, even if somewhat deficiently, as in one notable case, but we spare his blushes. A most excellent meal, to which we believe ten hungry club men did all justice, followed by, we believe, as excellent cigars, and a stroll round the garden, over which only the moisture and night could cast a gloom, brought us to the hour for lighting and departure. With most cordial thanks to Mr. Golding-Bird for his hospitalities, the decemvirate sallied forth into the keen night air. How we blundered and how we happened on the right road, and how we thundered through Green Street Green to Swanley and Sidcup, where we separated, are matters of history, and form part of the most pleasant and successful outings the club has ever enjoyed.

G. L. E.

Practical Surgery.

The Surgical Classes, held under the supervision of Mr. Lane, will be conducted during the Winter Session in a different manner than formerly. During the first period, by an arrangement made with Messrs. Down Bros., students attending these classes will be able to obtain a satisfactory acquaintance with all the important surgical instruments—a plan which will doubtless meet with universal satisfaction. During the second period Mr. Lane will demonstrate on the important Pathological Specimens met with in Surgery; while the third period will be devoted to practical instruction in bandaging, application of splints, etc. Senior students are reminded that candidates for the Final Examination must attend these classes to fulfil the requirements of the Conjoint Board.

Open Scholarships in Science and Arts.

SEPTEMBER, 1894.

Science.

First Scholarship of £150.—Thomas Francis Rutter, B.Sc., Balham Hill; University College, London.

Second Scholarship of £60.—John Thomas Dunston, Farnham; Guy's Hospital.

Certificates of Honour.—Francis William Brook, Peckham; Guy's Hospital. Ernest William Floyd, Manchester; Owen's College.

Arts.

First Scholarship of £100.—Arthur Pearson, London; Berkhamsted School.

Second Scholarship of £50.—George William Hare, Teddington; Blenheim House School, Teddington.

Certificates of Honour.—George Lewin, Clapham; City of London School. P. W. L. Camps, Islington; East Anglian School, Bury St. Edmunds. Charles Burrage Penny, Blackheath. Guy Theodore Wrench, Surbiton Repton School.

Dental.

Scholarship in Arts of £30.—Guy Chatterton, Peckham; St. Peter's College, Brockley.

Guy's Hospital, October 1, 1894.

Births.

MANLEY.—On September 19th, at New Street, West Bromwich, the wife of Herbert Manley, M.A., M.B., &c., of a son.

VINEY.—On September 22nd, at Harcourts, Chertsey the wife of J. E. Viney, M.A., M.D., of a daughter, prematurely.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* MR. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

OCTOBER 20, 1894.

Cancer of the Penis.

CLINICAL LECTURE BY MR. DAVIES-COLLEY.

The case on which I propose to lecture to-day is that of J. S., æt. 58, labourer, who was under my care in the Hospital in March last. Patient was admitted for "enlargement of the glans penis," on March 16th.

Family history.—Parents dead; one sister died of cancer of the uterus. Patient is a married man.

Previous illnesses.—Had gonorrhœa thirty-five years ago, of which he was cured; rheumatic fever five years ago.

Present illness.—About a year ago patient noticed a small pimple under the foreskin, situated at the edge of the glans penis on its dorsum. The pimple increased in size until patient was unable to draw back his foreskin. There was no pain, only occasional "twitchings." About four months ago patient noticed a slightly foul discharge, and an ulcer formed, which gradually involved about two-thirds of the surface of the glans as far as the meatus. A month ago he was advised to come into the Hospital.

On admission.—Patient is described in the report as a strong, healthy-looking man. On examination, the glans penis was found to be very hard, especially on the left side, the whole glans being very much swollen and increased in size. From my own notes I may also add that there was phimosis, a sanious discharge from an ulcer situated at margin of the prepuce, and about three-eighths of an inch in diameter, and there was a hard mass to be felt in prepuce as far back as corona. The report describes the ulcer as being indurated, and its edges everted and yellowish in colour. In this ulcer a "channel" was to be seen, which communicated with the meatus urinarius. Veins on dorsum of penis were distended and swollen. Patient was in no pain. The glands in groin were swollen and hard but movable, and they gave no pain on pressure.

Urine.—1030. Mucus; no albumin; no sugar.

Amputation was performed by the method I shall describe later to you, and the man was discharged cured on April 15th.

Cancer of penis, though not a rare disease, is far from common. I find that I have notes of only ten cases during the past twelve years. Cancers of lips, tongue, and breast are much more common.

Characters.—It is nearly always of the squamous epitheliomatous nature, sarcoma being very uncommon.

The growth generally begins in the mucous membrane of the glans or prepuce, and then infiltrates the cavernous tissue of the corpora cavernosa and the corpus spongiosum, and also the skin. The glands affected are those which lie horizontally near the external abdominal ring. Occasionally those extending along the internal iliac artery are affected, the cancer having been disseminated by the deep lymphatics of the part. When the disease is seen very late, the glands along the femoral vessels may be implicated, producing a serious state of things.

It is rare for cancer begun in penis to be disseminated to other organs—in none of the cases under my care was this so. A frequent cause of death is the implication of glands along the femoral vessels; these become adherent to the vein; there is then clotting in the vein, or death occurs from ulceration into vein, causing hæmorrhage.

The growth rarely causes much trouble in the passage of urine, and there is seldom any serious obstruction leading to subsequent cystitis and kidney trouble, as is common in cases of stricture and enlarged prostate. There is often also a remarkable freedom from severe pain even in advanced cases.

Age.—It occurs in late middle life and old age. In my ten cases the youngest was 45, the oldest patient 62, the average age being 55.

Causes.—

I. *Chronic balanitis*, that is, chronic inflammation of mucous membrane covering glans penis, and lining the foreskin. It may result from—

a. Congenital phimosis, the commonest cause. Hence the importance of circumcision in these cases.

b. The irritation of any urethral discharge.

c. Mucous patches, met with in the secondary stage of syphilis. Compare mucous patches on the tongue.

d. Gout in people of 50 and upwards.

II. *Old cicatrices*, from chancre, or injury. In one case of cancer in a cicatrix the injury had been caused by the bite of a horse. In this respect compare the results which may occur in the cicatrices of burns on other parts of the body.

Occasionally, as in this case, there will be a history of family predisposition to cancer.

Symptoms and diagnosis.—In many cases tolerably easy. There is enlargement of the end of the organ, a foul discharge, ulceration with large fungating granulations, and erosion. In addition the mass may be infiltrating the corpora cavernosa and corpus spongiosum, and causing enlargement of glands, which may, however, be only due to the discharge. It is sometimes difficult to recognise the malignancy of the disease in the early stage; it is important to recognise this, as early extirpation meets with such good results. In such an early case you will find phimosis with an ulcer underneath the prepuce, and some thickening, and you will be unable to draw back the prepuce; here the age of the man should be considered, and the absence of evidence of venereal affection. In such a case you must slit up the prepuce and make a more careful examination under an anæsthetic. This was done in the case I have described to you. I found a large mass of warty-looking growth infiltrating the prepuce inside, and sprouting to an elevation of a quarter of an inch above its mucous membrane. There was also a smaller mass in the glans, with well-marked eversion of the edges.

In the diagnosis of cancer of the penis bear in mind that two forms are to be met with; they are—

1. The warty.
2. The ulcerative.

I. You will have to recognise a simple warty growth or papilloma from a cancer.

A papilloma occurs as a result of discharge due to gleet or uncured gonorrhœa, also after the mucous patches of secondary syphilis. The best way to distinguish a simple warty growth or papilloma from cancer, is to examine firstly, whether there is any erosion or ulceration destroying the natural tissues of the part, and secondly, whether there is any sign of growth infiltrating the deeper structures of the penis. Papillomata are superficial growths, and they occur as *an addition* to the normal tissues, without any erosion. If you are still unable to make certain of your diagnosis, snip off a piece of the wart and examine microscopically.

II. The *ulcerative* form is usually easy to recognise by its everted margins, and the extensive induration of the deeper tissues. If these signs are absent, it may be difficult to distinguish from a venereal sore. In such a case the history may be of some help. You may also look for signs of constitutional syphilis, and it may be necessary to try first the ordinary remedies for a venereal sore. A slight enlargement of the inguinal glands is not of much assistance in diagnosis, as it may depend upon many other causes besides cancer.

Treatment.—Early and complete removal, preferably with the knife. Amputation with the galvanic écraseur, which was at one time the popular operation, is objectionable because it leaves a sloughing surface, and is apt to be followed by a contracted urethral orifice.

The *contra-indications* of operation are when glands are enlarged in the femoral canal and iliac fossa.

The following points should be borne in mind when operating for cancer of penis:

1. Keep quite clear of diseased part, giving a good margin.
2. Be careful about hæmorrhage, which is difficult to arrest from the vessels in the cavernous tissue.
3. Manage the division of the urethra so as to avoid subsequent traumatic stricture.
4. Remove enlarged glands freely.

Operation.

(1). In cases where only a portion of penis is implicated. Having selected the few instruments necessary, the penis is compressed at its base with a piece of elastic tubing held by a Spencer Wells' forceps. Selecting a small-bladed knife, and holding the penis as far as possible symmetrically, make two lateral flaps through the skin and turn them back. Keeping well away from the growth, make a transverse incision through the corpora cavernosa until the fibrous tissue separating them from the corpus spongiosum is reached. The distal end of the corpora cavernosa is next dissected carefully away from the corpus spongiosum for a short distance forward, and then the corpus spongiosum is transversely divided so that the stump projects half-an-inch in front of the section of the rest of the penis. With a pair of scissors, split the urethra along its floor as far up as the exposed end of the divided corpora cavernosa. Having firmly secured with fine catgut ligatures the divided vessels, particularly the dorsal arteries of the penis, the arteries to corpora cavernosa, and the artery to the bulb, and removed the elastic tubing, the skin flaps should then be brought forward and sutured in the following manner: the upper halves of both flaps are brought together over the cut ends of the cavernous bodies, while the lower halves are sutured to the edges of the mucous membrane lining the split part of the urethra. In this way, any fear there may be of subsequent stricture of the urethra, is completely obviated.

(2). In cases where it is desirable to amputate the entire organ, make an incision down the middle line of the scrotum and expose the whole of the bulb of the corpus spongiosum, with the divergent crura of the corpora cavernosa. Separate the corpus spongiosum from the corpora cavernosa, and remove the latter as freely as may be necessary. You may even peel off the crura with a blunt dissector from the arch of the pubes. The corpus spongiosum should then be cut through

about an inch in front of the triangular ligament, and its end should be separated from the triangular ligament and attached by sutures to the median incision in the perineum, so that the urethra is now placed behind the remains of the scrotum. In some cases it may be expedient to remove the testicles before closing up the rest of the skin incision with sutures.

As to recurrence of cancer of the penis after its removal by amputation, my experience has been favourable, but it is very important to operate early, and to clear away all suspicious glands as well as to cut wide of the growth.

A Case of Alcoholic Peripheral Neuritis.

CLINICAL LECTURE BY Dr. HALE WHITE.

Gentlemen,—The patient before you, who is now in Stephen ward, under me, is a labourer, æt. 36, who has drunk hard, and who first came in under Dr. Pitt, in April, 1888. In February, 1888, he first experienced weakness of the feet. This spread up the legs, and finally invaded the hands and arms. He had also had numbness and pricking sensations in the toes and fingers. On admission, in 1888, he was unable to stand, his hands and arms were weak, movements were ataxic, the hands were tremulous. Tactile and painful sensations were much impaired below the elbow and over the whole of the lower extremities, the muscles of which were painful on pressure, especially those of the calves. The knee-jerks were absent, and the plantar reflex was slight. Some muscles showed a slight reaction of degeneration. He left in September, 1888, able to walk and much improved.

Since his discharge he has sometimes got drunk, and on September 16th, 1894, he drank half-a-pint of gin in the evening. The next day he felt weak in the legs, and had tingling in them and in the arms.

On admission, September 24th, he was as you see him now, except that the symptoms were more severe. He cannot stand; the muscles of the lower extremities are very weak. You notice there is well-marked foot-drop. His hands and arms are very weak; there is slight wrist-drop, the dynamometer shows only 15 in either hand, and the movements of both are ataxic. There is great tenderness of the calves, of the soles of the feet, and in between the toes; the external popliteal nerves are slightly tender. Tactile and painful sensations in the feet are diminished; temperature sense is unaffected. Sense of localization impaired. The sensory symptoms are similar in the upper extremities. Knee-jerk and plantar reflexes absent; slight reaction of degeneration in some muscles. The heart, respiration, bladder and rectum are unaffected. There is no evidence of cirrhosis. It is stated that when he was seen at Out-patients, on September 20th, the knee-jerk was increased. He has not complained of cramps. He was kept at rest in bed, with sand bags to support the feet, and was given mv. of Liquor Strychninæ Hydrochloratis subcutaneously once a day. As he showed signs of twitching, this was, on October 2nd, left off, and he was given Cod Liver Oil and Iron and Quassia mixture. At first the weakness and sensory symptoms increased, but lately he has improved in all respects.

Now, gentlemen, in this case the diagnosis did not give rise to any difficulty, for the intense tenderness of the muscles showed that some local disease was present there, and we know of no disease of the muscles themselves accompanied by this intense tenderness, and therefore we concluded that it was due to inflammation of the minute nerves lying in between the muscular fasciculi—in fact, that the patient had peripheral neuritis. Having made this diagnosis, the next thing to do was to see whether the presence of other symptoms confirmed it.

1. *Sensory symptoms.*

(*a*). Tenderness of nerves. Peripheral neuritis, as its name implies, affects the smaller twigs of nerves rather than the larger branches, hence the muscular tenderness which can be elicited by griping a muscle and so compressing the nerves in it, is by far the most important diagnostic sign of peripheral neuritis. It is, as in this case, especially well marked in the calves in the alcoholic form. Nerve tenderness is next best observed in the nerves of the feet; hence, as in our patient, there is great tenderness of the digital nerves on pressure between the clefts of the toes and of the internal plantar nerve on pressing on it where it becomes superficial, and it is less marked over the external popliteal, ulnar and musculo-spiral nerves. Sometimes the cutaneous nerves are affected, and consequently the skin is excessively tender, as in a woman under my care in Miriam. So marked was this symptom in her, that the bed-clothes had to be kept off the legs by a cradle.

(*b*). Impairment of function of sensory nerves. Now, you would expect that in the early stages of the disease there would be signs of irritation, followed by loss of function, and this is exactly what happens. Our patient complained of having had a pricking sensation in the feet, and tingling and pricking are very commonly experienced in the early stages of peripheral neuritis. Patients also sometimes complain of a burning sensation. Later we get evidence of loss of function; the patient has patches of anæsthesia distributed irregularly about the extremities. Generally this anæsthesia—as in the man before you—refers to both tactile and painful impressions. He also is unable to locate accurately the point of contact when he is touched with a pin. A patient who was in Mary ward last year was often ten inches out. The temperature sense is normal in our present patient; but quite commonly it is seriously impaired, as, for instance, in the woman just referred to. It is usually stated that

the muscle sense is rarely impaired; but last year two women were in Mary ward, at almost the same time, who both showed considerable impairment of this sense.

2. *Motor symptoms.*—In the early stages of peripheral neuritis, the motor symptoms are indicative of irritation, and the patient may have cramps from painful contractions of the muscles. This was very marked in a case Dr. F. Taylor has recorded. The irritative stage soon passes off, and the muscles lose power in varying degrees; some are often completely paralysed. It is a curious thing that the muscles of the head, face, neck, and trunk, usually escape, and the paralysis is commonly more evident in the hands and toes than in the rest of the extremities. The neuritis, therefore, is not only peripheral as regards the ends of nerves, but also as regards the periphery of the extremities. Further, one arm or one leg is hardly ever affected unless the other arm or leg also suffer. I can demonstrate all these points to you in the present patient. With such a disease as peripheral neuritis it is, of course, extremely unlikely that all the muscles moving any part and all portions of each muscle will be paralysed in equal degree, and, therefore, some ataxy of movement may be present. You see it well when this man attempts to touch my finger. It is very important that you should remember this, for if not, you may conclude that a patient has locomotor ataxy, when in reality he is suffering from peripheral neuritis. The tremor met with in some cases may perhaps be due to the uneven manner in which, owing to the peripheral neuritis, impulses can arrive at the muscles.

The broad outline, then, that we have learned, is that a patient with peripheral neuritis will come to you because of bilateral loss of power in the extremities, beginning at their periphery and spreading up them. You will find the muscles very tender on pressure, and he will tell you that the disease began with numbness and tingling. The other symptoms to which I want to direct your attention are:—

3. *Reflexes.*—The important fact to be grasped is that the knee-jerk is nearly always absent—a fact of great diagnostic value. Its absence is not surprising when you know that for its production a reflex arc is necessary, consisting of afferent nerves from the muscles of the thigh, probably the vastus internus, spinal cord cells, and efferent nerves to the quadriceps. When you tap the patella tendon, tension is put upon the afferent nerves, consequently they are stimulated and the jerk takes place. The knee-jerk is so commonly and so early lost in peripheral neuritis, long before the quadriceps is unable to move the leg, that we may conclude that the afferent nerves are very prone to be affected early in this disease. But for many years I have taught—and I think now it is generally admitted—that much more commonly than it was formerly thought the knee-jerk is, very early in the case, during the irritative stage, decidedly increased for a little while. This increase is often overlooked because it lasts for so short a time, is so quickly succeeded by loss, and occurs so early. The knee-jerk was observed to be increased in our patient four days after the commencement of his illness. Last year I saw a man in whom the knee-jerks were absent, but when he first put himself under his doctor's care they were very excessive. But the most remarkable case I have met with was that of a woman in an advanced condition of alcoholic neuritis with foot-drop and no plantar reflex, although a knee-jerk was present. The other deep reflexes, as the wrist and elbow-jerks, are usually absent. The condition of the superficial reflexes depends entirely upon the degree of affection of the cutaneous and muscular nerves, usually—as you see in our patient—they are absent. If there is hyperæsthesia of the skin they may be exaggerated.

4. *Reaction of degeneration.*—The patient before you exemplifies the usual condition, for a complete reaction of degeneration in any muscle is decidedly rare, and he had only a partial reaction. Most often, as in his case, there is a diminution of the Faradic excitability, and in some of the muscles a reversal of the normal formula for galvanism. Probably the reason why the reaction is partial is that, as the neuritis is chiefly of the smaller nerves in between the muscular fasiculi, different parts of the same muscle have different degrees of the reaction, while in some parts the reaction is normal. The result is that the muscle as a whole shows an atypical reaction of degeneration.

5. *Muscular Wasting.*—In an advanced case the wasting is extreme, as you may often see; but if the patient quickly begins to mend, as is the case with the man before you, little or no wasting will be present. Another reason why wasting often is not noticed probably is that some fibres only of the muscles are wasted, so that wasting of the muscle as a whole is difficult to detect. From what you have learned about the peripheral distribution of the neuritis, you hardly require to have it pointed out that wasting of the intrinsic muscles of the hand and foot is especially likely to be seen, and that is undoubtedly so, but the wasting may be very extensive, as, for instance, in a woman in Mary in whom the glutei were markedly atrophied.

6. *Deformities.*—These are of the utmost importance, and our patient shows the two commonest, which are almost diagnostic of peripheral neuritis. You see that when he puts his arms out his hands drop, because his extensors are more paralysed than his flexors; in other words, he has wrist-drop, and you see that his feet drop, because the extensors on the front of his leg are more paralysed than the flexors on the back. Remember, therefore, it is a rule that in peripheral neuritis the extensors are weaker than the flexors, and, therefore, wrist-drop and foot-drop are of the utmost importance. Many other deformities may be seen in peripheral neuritis due to the unequal paralysis of muscles, but we will not examine them now, as our patient does not show them. If the case lasts long and is improperly treated, serious permanent deformities result from this unequal paralysis of the muscles. It is your duty to be specially

careful to prevent these. If the patient is able to walk, the foot-drop gives rise to a characteristic high-stepping gait, which I often pointed out to you in a patient in Mary last summer. The patient raises the heels too high when she walks, indeed they may hardly even touch the ground, and she walks on the toes, because, owing to the paralysis of the extensors, they always drop down and the sole of the foot cannot be got horizontal. Occasionally, when the atrophy of the muscles is very marked, that of itself will give rise to deformities.

7. *Trophic disturbances.*—These are not common in rapid cases like the one before you; but sometimes you see attacks of flushing, the feet, for instance, become red and the patient complains of burning; at other times, vascular constriction leads to pallor and coldness. You will remember that in a clinical lecture, last year we discussed the importance of this in connection with Raynaud's disease and erythromelalgia. As the case becomes chronic, trophic disorders are more often seen, but they can hardly be called common. The skin becomes dry and glossy, especially that of the fingers, as in a typical case in Stephen some four years ago. The nails and hair become brittle and there may be arthritic adhesions; but I think, on the whole, trophic lesions are more often seen in neuritis of individual nerves than in multiple neuritis, as an instance of which I may mention the case of a patient suffering from rheumatic neuritis of the middle and internal cutaneous nerves of the left thigh, which was accompanied by a herpetic eruption along them. Never forget the fact– valuable for diagnosis—that bed-sores are very rare in peripheral neuritis.

8. *The Pulse.*—The condition of this is of the utmost importance, for in severe cases if the vagus is affected with neuritis the pulse becomes rapid and irregular, and the patient dies from cardiac failure. I can give you the following cases of rapid pulse in peripheral neuritis I have recently seen. A woman admitted into Mary, February 14th, 1893—pulse very rapid; in spite of digitalis the rapidity increased to 160, and she died February 18th. Two other women in Mary had pulses of 110 and 96 respectively. A man, a typical case, pulse 120, and very irregular, even while in bed—he recovered. A woman, when first seen, pulse 120; twelve days after, pulse 160; death eight hours after she was last seen. You see, therefore, that death from cardiac failure, the symptoms of which are a rapid and irregular pulse, is by no means uncommon in peripheral neuritis—in fact, I think you will find it to be the most frequent way in which neuritis kills the patient.

9. *The Respiration.*—Neuritis may affect the phrenics. This was so in a man I saw in Bright ward. He had, as a consequence, irregular and feeble action of the diaphragm, the lungs became blocked, and he died of pneumonia. Sometimes you will find the diaphragm completely paralysed. Please, therefore, bear in mind that neuritis of the phrenics may occur, and that it is a most serious complication.

The points we have just gone over refer to all cases of multiple peripheral neuritis. Now I want to direct your attention to points especially characteristic of the alcoholic variety.

(*a*) It is much commoner in women than in men.

(*b*) The local tenderness of small nerves and muscles is very marked.

(*c*) The extensors on the front of the leg are first affected, hence the high-stepping gait already mentioned and the ankle-drop are early and diagnostically very important symptoms. Wrist-drop comes later.

(*d*) The symptoms of cirrhosis of the liver are not as common as you would expect. Often, as in our patient, there is no evidence of it. Perhaps the reason is that if after absorption the alcohol is arrested by the liver, it sets up cirrhosis, and being stopped there does not get into the general circulation and so affect the peripheral nerves. As cirrhosis is often absent, so also some patients with alcoholic neuritis do not complain much of digestive troubles.

(*e*) Cramps and tremors are more common in alcoholic than other forms of neuritis.

(*f*) The mental symptoms which are frequent as the result of alcohol are commonly associated with alcoholic neuritis. Perhaps the most characteristic are the deceit which women will practise to obtain alcohol, and the lying with which they will cover their deceit. About both the lying and the deceit there is often a repulsively degrading selfishness. I know the case of a woman who was out of health; no cause could be found. Her husband was determined to try and cure her depression, so he resigned his prospects and position in England, and went to the expense of taking his wife round the world. She was perfectly aware that this was an enormous sacrifice, yet she allowed it, although she knew that the cause of her trouble was her habit of Eau de Cologne drinking. She was accidentally found out when they returned. It will often take you many many days of careful observation to detect the secret drinking, and even when you have found it the patient will deny to your face that she drinks, as calmly and unblushingly as if she were discussing the weather. Do not forget Eau de Cologne. I have known two or three cases of this, and one of methylated spirit drinking.

Treatment.—This is useless, unless the alcohol is stopped absolutely. This often means putting the patient in a home under trustworthy nurses, for she will bribe her own servants to get the drink somehow or another. The next thing, and of immense importance, is complete rest in bed, and the patient must not be allowed to be cold. If the case is not too acute, galvanism and massage of the muscles will be of great use to keep up their nutrition, and will in every way benefit the patient, but they must not be used if there is much tenderness or pain. Strychnine subcutaneously is often given for the

same reason in chronic cases, for which also mercury and iodide of potassium may be employed as absorbents, frequently, I am sure, with benefit. Cod liver oil and iron are often of use, and the patient before you has great faith in their efficacy, although usually they are given more for the chronic forms. Never forget that if you do not keep the foot supported when ankle-drop is well marked, it may become fixed in a useless position, so that when the patient is well of her neuritis, you will have to put her under another course of treatment to rectify her deformity, for which she will not thank you.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	3, 16.	Ulcerative endocarditis.
	7.	Aortic regurgitation.
	19.	Pericarditis. Mitral and tricuspid regurgitation.
	26.	Aortic and mitral regurgitation. Chronic tubal nephritis. Albuminuric retinitis.
	31, 42.	Chlorosis.
	38, 48.	Mitral regurgitation.
	49.	Mitral and tricuspid regurgitation.
Philip	1.	Aortic and mitral regurgitation.
	8, 13.	Aortic aneurysm.
	16.	Aortic stenosis and regurgitation.
	18.	Mitral regurgitation.
	24.	Adherent pericardium. Mitral regurgitation.
	26.	Mitral regurgitation.
	37.	Mitral stenosis and regurgitation.
Stephen	1.	Mitral regurgitation.
	5.	Aortic stenosis and mitral regurgitation.
	7.	Mitral regurgitation.
	27.	Aortic aneurysm.

Nervous System.

Mary	9.	Optic neuritis.
	12.	Cerebellar tumour.
	14.	Hysteria.
	15.	Diphtheritic paralysis.
	21.	Chorea.
	32.	Paraplegia. Secondary growths in spinal column or meninges.
Philip	2.	Sciatica.
	6.	Vertigo.
	11.	Paraplegia following injury to back.
	31.	Locomotor ataxy.
Stephen	12.	Cerebral tumour. Optic neuritis.
	17.	Paraplegia: myelitis.
	20.	Right hemiplegia.
	21.	Peripheral neuritis.

Alimentary System.

Mary	2, 28, 46.	Gastric ulcer.
	23.	? Gastric ulcer.
	24.	Chronic gastritis.
	27.	Ascites.
	33.	Vomiting. Scirrhus mammæ.
	38.	Œsophageal stricture.
Philip	12.	Hæmatemesis. Cirrhosis of liver.
	14.	Dysentery.
	19.	Gastro-enteritis.
	20.	Pancreatic cyst.
	35.	Ascites. Cirrhosis of liver.
Stephen	39.	Carcinoma of stomach.

Typhoid Fever.

Mary	5, 10, 18, 20, 35, 36, 45, 50.	
Philip	9, 34, 36, 37, 38.	

Genito-Urinary System.

Mary	5.	Chronic tubal nephritis.
	30	? Movable kidney.
	37.	Chronic tubal nephritis.
	43.	Chronic tubal nephritis. Ascites.
Philip	21.	Diabetes mellitus.
	25, 38.	Chronic tubal nephritis.
Stephen	26.	Granular kidney.

Respiratory System.

Philip	17.	Asthma.
	27.	Broncho-pneumonia.
	28, 29.	Pleuritic effusion.
	33.	Empyema.
Stephen	2.	Empyema.
	8.	Diaphragmatic pleurisy.
	24.	Plastic bronchitis.
	36.	Hæmoptysis.

Phthisis.

Mary	1, 17, 41.	
Philip	10, 16.	
Stephen	28, 30.	

Miscellaneous.

Mary	4.	Acute tonsillitis.
	11.	Raynaud's disease.
	13.	Œdema. Anæmia. Wasting. Vomiting. ? Tubercle.
	25.	Chronic ulcer of leg.
	29.	Dermatitis and pedicularis.
Philip	4.	Malaria.
	5.	Malarial neuritis.
	6.	Anæmia. ? Cause.
	15.	Plumbism. Cysticercus acanthotrias.
	32.	Osteo-arthritis.
Stephen	3.	Erythema nodosum.

Acute Rheumatism.

Mary	40, 47.	
Philip	1, 39.	
Stephen	15.	

Three Cases of "Pyrexia Innominata" from the same House.

(Communicated by the Medical Registrar.)

One of the patients was a man, æt. 42; the other two were girls, æt. 13 and 17 respectively, daughters of the above. They were sent up from the South Eastern Fever Hospital as cases of typhoid, and were admitted as such. There appears to have been an epidemic of some febrile disease in the neighbourhood. In the next house but one eight people were taken ill, and in the patient's house the lodger was taken ill three weeks ago and died four days after. The death certificate stated the cause of death to be influenza.

I.—Under Dr. Pitt.

Philip.

23. W. S., æt. 42. Admitted September 3rd, for pyrexia, weakness and delirium. Fourteen years ago he was in the Hospital for erysipelas. Five years ago he had an attack of influenza. He has been suffering from pain in his back and chest for the past two months, and has been treated for bronchitis. Fourteen days ago he came home and complained of giddiness, rigors, and vomiting; he went to bed, became delirious, and was attended by his club doctor. His wife states that he has repeatedly attempted to get out of his bed, and that he talks a deal of rubbish. He had diarrhœa one day previous to admission.

Condition on admission.—Temperature 100; pulse 94; respiration 28. Sallow complexion. Lips dry and peeling; breath foul; tongue dry, yellow and cracked. Duputyren's contraction of fingers. Hoarse stammering voice, deaf, drowsy, stupid and incoherent. If shouted at seems to wake up a little, but soon relapses into his former condition. Pupils equal, and they react to light.

Abdomen.—A little distended and tense; no pain or tenderness on pressure; no spots. Liver and spleen not felt, and their area of dulness not increased.

Respiratory system.—Barrel-shaped chest; few rhonchi heard, especially over the left side.

Circulatory system.—Pulse 94; regular and compressible. No visible or palpable cardiac impulse. No cardiac dulness. Heart sounds normal.

Urine.—1020, neutral; gives Ehrlich's reaction.

Late in the day temperature 101; the highest during his stay in the Hospital.

September 5th. Delirious; attempts to get out of bed. Temperature 97·2; respiration 32; pulse 84.

7th. More rational; answers questions. Says he feels weak and languid. Urine does not give Ehrlich's reaction.

He gradually gained strength, and was dismissed on September 28th. The temperature did not rise above 98·8 after September 5th.

II.—Under Dr. Hale White.

Mary.

2. M. S., æt. 17. Admitted September 3rd, for headache and abdominal pain. She had measles when a child; has not been ill since until fourteen days ago, when she went to bed complaining of headache, accompanied by pain in the back and feverishness. She has been under medical treatment. She has been deaf and delirious; her sputum has been streaked with blood. She has been on milk diet.

Condition on admission.—Temperature 100; pulse 100; respiration 32. She is anæmic; thin. She does not answer questions readily, and is very listless.

Respiratory system.—No dulness or deficient movement. Rhonchi heard over the left side of the chest behind and in the left infra-axillary region.

Circulatory system.—Normal.

Alimentary system.—Tongue red and dry; lips dry. Abdomen not distended; slightly tender on palpation; no spots. Liver and spleen not enlarged.

Urine.—Pale, 1020, acid; no albumin, sugar or blood; it does not give Ehrlich's reaction.

September 4th. Temperature 98; pulse 84; respiration 20. No diarrhœa.

5th. Temperature 99, at 6 o'clock p.m. Tongue a little furred. She is slightly deaf and very apathetic.

She was discharged on September 21st. After the 5th the temperature did not rise above 99.

III.—Under Dr. Goodhart.

Mary.

20. M. A. S. Admitted September 3rd, 1894, for vomiting and headache. She left school six months ago, and since then has been living at home. About August 22nd, she began to suffer from a severe headache and general malaise, this continued until August 29th, when she began to feel faint and ill, and, on August 30th, she took to her bed, and vomiting began on this day, and has continued every morning until admission. For some days she has been constipated, and this has necessitated several enemas.

Condition on admission.—Temperature 103; pulse 112; respiration 30. She is well nourished. Her face is flushed.

Alimentary system.—Breath foul. Tongue red and coated with thick creamy fur. Appetite bad. Abdomen not distended or tender. No typhoid spots visible. The spleen can be felt just under the left costal margin; the area of dulness is slightly increased. Liver dulness normal.

Circulatory system.—Normal.

Respiratory system.—Normal.

Urine.—1028 and dark orange colour. No albumin r sugar. Ehrlich's reaction not given.

September 4th, at 6 p.m. Temperature 104; pulse 124; respiration 36. The lowest temperature to-day was at 10 p.m., when it was 102·6. A diagnosis of typhoid ever was made; treated with application of ice-bag to her head. Milk diet and sponging, if temperature rises above 103·4.

5th. Temperature ranged between 101·8 and 104·2; pulse between 96 and 120; respirations between 32 and 40. She was sponged three times during the day. She complains of a little pain under the left costal margin.

6th. Temperature between 101 and 105·8 at 6 p.m., when she was sponged. Urine gave Ehrlich's reaction.

7th. Temperature between 101 and 103; a pulse tracing showed marked dicrotism.

8th. Temperature between 101·4 and 103·2. Bowels open twice. Complains of epigastric and umbilical pain.

9th. Temperature between 99·2 and 101·2. Bowels opened once.

10th. Temperature 98 to 99·4. Appetite better; she complains of being very hungry. The temperature did not rise above 99 after this date, excepting on September 25th, when it was 100. On the 13th, Dr. Goodhart altered the diagnosis from typhoid fever to pyrexia innominata; the rapid fall of temperature and the absence of spots throwing much doubt on the original diagnosis.

Chronic Gastric Ulcer—Perforation into the General Peritoneal Cavity—Laparotomy—Ulcer Sutured—Death from Pneumonia Five Days Later.

James F., æt. 45, was admitted into John ward, on September 10th, at 7.30 a.m., under the care of Dr. Perry, for acute abdominal pain.

At one time patient was a heavy drinker, but for the last year or so he has been more abstemious.

There is a history of hæmatemesis twelve years ago, at which time he was in the Rotherhithe Infirmary, but on enquiry no particulars of this illness can be obtained. Three weeks ago patient was attending as an out-patient at St. Bartholomew's for abdominal pain and constant sickness, but there was no hæmatemesis. This attack lasted one week, and was thought to be due to cirrhosis of the liver.

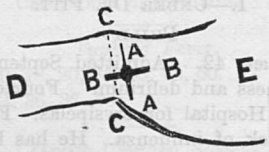
On Sunday, September 9th, the day before admission, patient had his ordinary mid-day meal; at 7.30 in the evening he took some winkles with bread and butter; he then went out for a walk, and drank some beer. At 10.45 p.m., shortly after he had returned home, he was suddenly seized with abdominal pain, which was most severe in the epigastric region.

He was admitted into the Hospital at 7.30 a.m. on Monday, the 10th. He was suffering from acute pain in the epigastrium; the abdomen was so rigid as to render complete examination of the viscera impossible; there was no distension; resonance was normal; there was no movement on respiration; the patient did not present marked symptoms of collapse; the pulse rate was sixty per minute, and the beats not at all feeble.

Dr. Perry diagnosed a perforated gastric or duodenal ulcer, and Mr. Symonds was immediately summoned.

A.C.E. mixture was administered, an incision five inches long made in the abdominal wall, and the peritoneal cavity was opened. The liver was exposed and found to be quite healthy; lying in front of it was a quantity of bile-stained fluid. The liver was then pulled upwards and outwards by its anterior edge, and the pyloric end of the stomach with the commencement of the duodenum brought into view; a small perforation about one-eighth inch in diameter, circular in shape, was seen just to the cardiac side of the pyloric ring; the thickening round the ulcer could be felt to extend about one and a half inches in the direction of the stomach, and one inch in the direction of the duodenum. From the orifice was escaping thick bile-stained mucus of acid reaction.

Mr. Symonds, with scissors, enlarged the orifice in a direction parallel with the long axis of the stomach for about one-third inch in each direction; the edges were pared, and the ulcer curetted by means of a sharp spoon, passed into the stomach; the edges were then brought into apposition by means of ten Lembert's sutures, as indicated in the diagram.



E = stomach.
D = duodenum.
C C = pyloric ring.
B B = perforation and cuts made with scissors.
A A = edges after suture.

The cavity of the peritoneum was thoroughly irrigated with sterilized water, the tube being passed into all possible interstices. During this process the patient ceased breathing, but was soon restored by artificial respiration.

The wound was closed by fishing-gut sutures, and an antiseptic dressing applied.

Patient complained of a good deal of pain at the seat of the wound, and was a little sick once or twice during the day. He had two morphia injections, which relieved his pain. He was fed by the mouth with small quantities of milk, frequently repeated, the first dose being given six hours after the operation.

Up to the time of his death there were no signs whatever of peritonitis; no abdominal distension; no tenderness except over the seat of the wound; his pulse was good; the vomiting ceased after the effects of the A.C.E. mixture. His temperature did not rise above 100 until the 12th, when it reached 101·4, and kept at this high level till death. On the 11th, he complained of mucus in his throat—this grew worse, and bronchitis was found to be present; his breathing became difficult, his chest full of rhonchi; the respirations were increased in frequency to 40 per minute; dyspnœa became extreme, and he died early on the 15th.

Post-mortem by Dr. Pitt.—Pleuræ: lymph and ecchymoses at posterior part of both lungs; right lung: pneumonia in upper two-thirds of lower lobe and lower third of upper lobe; grey stage; left lung moist, no pneumonia.

Stomach: the series of stitches in serous coat had closed the aperture of the ulcer tightly. No signs whatever of peritonitis. The specimen was kept for the Museum.

L. A. P.

Case under Dr. Hale White.

Stephen.

36. C. E., æt. 10. Admitted on September 28th for pyrexia, headache, pain in back and general malaise. Patient appears very dull, and cannot give a detailed account of his illness. His relatives have not been seen, but the boy says he has been ill a fortnight. He is dark with a dusky skin.

Pulse.—92; regular; small and weak.

Heart.—Normal; tache cérébrale present.

Respiratory system.—Movement good; normal percussion note; râles at both apices; vesicular murmur harsh; respiration 20.

Alimentary system.—Lower-lip sore, as is the side of tongue, of which the dorsum is white and furred, but not "typhoid" in character. There is dysphagia, with coughing up of food, which does not return through nose. Abdomen lax and retracted, not tender; no spots. Liver and spleen not palpable. Bowels loose and motions pale. Good control over sphincters. Skin hot and dry.

Genito-urinary.—Urine dark; sp. gr. 1030; no albumin, blood, sugar or pus; does not give Ehrlich's reaction.

Nervous.—The left arm and leg are hardly ever moved, but the right limbs more readily. Patient is very deaf, which was first noticed on the 21st. There is no discharge from either auditory meatus; discs normal. During the night he got no sleep, and was delirious in the morning; could be roused when spoken to; some conjunctivitis.

26th. Has vomited six times; passed two motions which were pale, offensive and liquid, and contain undigested milk. Patient is comatose. Pulse, temperature and respiration are rising. Peptonized milk was given and brandy ʒij 2 dis horis.

Dr. Hale White saw patient, and it was noticed that the left arm and leg did not move so well as the right. He thought that if this difference did not persist, the diagnosis inclined to typhoid in preference to meningitis, as the nature of pyrexia, history of fourteen days, and diarrhœa were of greater weight than the absence of abdominal distension, absence of spots and enlarged spleen, but said the point was still doubtful.

27th. Patient delirious all night; has lost control of sphincters; has been sick. Left side of body is still very quiet; left leg is colder than the right. Patellar reflexes present. Temperature 103; pulse 144; respiration 54. Nutr. Enem., 4 tis horis; brandy, ʒss 4 tis horis; 9 p.m., Inj. strych., ɱv., Inj. brandy, ɱxv.

28th. Patient sinking. Pulse 184; respirations—Cheyne-Stokes, 60; numerous râles; slight left facial paralysis. Temperature has been rather higher in right axilla all night; no more vomiting; bowels open once. Patient died from respiratory exhaustion at 2 p.m.

At the autopsy there was extensive suppurative meningitis at the base and over two-thirds of vertex; pus in middle ear; no sub-dural abscess or thrombosis of lateral sinus. *Membrana tympani intact.*

As the father had left the wrong address, no history could be obtained, but his mother afterwards said that four weeks before he had had left earache and discharge for one day; had not since complained of any trouble.

Dr. Hale White, on his second visit, entered fully into the differential diagnosis between typhoid and meningitis, and said that when first seen there was special difficulty in this case, in the absence of previous history and the coma of patient. The absence of spots could not be certain as the skin was so dark, and the history was long for meningitis, which would probably have proved fatal before. But after the first visit, the persistence of the great weakness of the left arm and leg; the slight facial paralysis; the inequality of the temperature in the two axillæ, and to a much less extent, the severe delirium, the loss of control over the bladder and rectum, and the vomiting rendered a diagnosis of meningitis almost certainly correct. The slow pulse, the deafness, and the headache were common to both diseases.

In the Surgical Wards.[1]

Cases under Mr. Howse.

Naaman	17.	Enlarged thyroid, left lobe. Previous removal of right lobe.
Charity	13.	Irreducible femoral epiplocele.

Cases under Mr. Davies-Colley.

Luke	1.	Acute osteo-myelitis.
	9.	Popliteal aneurysm. Femoral previously tied in Scarpa's triangle. Now tied in Hunter's canal.
	11.	? Rheumatoid arthritis in hip.
	15.	Mental incapacity following blow on the head. Tender spot. Trephining.
	20.	Senile gangrene foot. Amputation through thigh.

Cases under Mr. Lucas.

Accident	8.	Colles's fracture and fractured ribs.
	15.	Ruptured quadriceps tendon.
	20.	Fractured jaw.
Lydia	Cot.	Spinal caries. Extensive abscess over spine.
	10.	Hydrocele of cord.
	15.	Extra-capsular impacted fracture neck of femur.
Job	2.	Varicocele.
	4.	Mastoid abscess.
	17.	Enlarged prostate. Retention.
	23.	Multiple abscesses in connection with spine, ulna, etc.
	7.	Amputation of leg for shortened contracted leg, resulting from infantile paralysis.
		Locomotor ataxy. Inflamed corn. ? Perforating ulcer.
Charity	35.	Acute mammary abscess.
	Cot.	Acute arthritis. Hip.
	5	Carcinoma mammæ.

Cases under Mr. Golding-Bird.

Martha	1.	Dental caries. Abscess. Trismus. Anæsthesia of chin.
	2.	Chronic abscess in middle line of abdominal wall just above pubes, and *secondary to caries of os pubes.*
	5.	Solid enlargement of bursa patellæ.
	20.	Neuritis (ulnar nerve) following inflammation about inner condyle of humerus.
	—.	Cleft palate.
Lazarus	6.	Cleft palate.
	17.	Phlebitis.
	13.	Syphilitic nodes: skull, clavicles, etc.

Cases under Mr. Jacobson.

Naaman	21.	Sarcoma arising from pelvis. Removal.
	22.	Bullet wound of head; sinus leading deeply into brain.

Case under Mr. Symonds.

Martha	13.	Carcinoma recti. Colotomy.

Case under Mr. Lane.

Job	13.	Stone removed previously from kidney; recurrence of pain.

Nursing News.

On October 10th Miss Bessie Pitt Parret was appointed Night Superintendent. Miss Parret worked for six years as probationer and staff nurse in our wards, and since last May has held an appointment in the Government Hospital at Poona, India. We are glad to welcome her back to Guy's.

Miss Florence Cross is appointed Sister of Martha ward. She will enter upon her duties on the 5th of November.

Sister Miriam, we are glad to be able to say, is now tolerably convalescent, and will be ready to start for change of air in the course of the next few days.

Guy's Hospital Dental Department.

Practice during September, 1894.

Gold Fillings		95
Amalgam ,,		210
Osteo ,,		
Perm. G.P. ,,		
Artificial Crowns		11
Dentures		10
Dead Teeth		47
Scalings		17
Regulations		2
Attendance for Extraction under Anæsthetics		1033
,, ,, without ,,		684
Total		2109

Returns of Examinations

BY THE COLLEGE OF SURGEONS AND CONJOINT BOARD DURING THE PAST COLLEGIATE YEAR.

F.R.C.S.

	No. of Candidates.	Passed.	Referred.	Percentage of Passes.
First	160	62	98	38 per cent.
Final	99	54	45	54 ,,

First Conjoint (Five Years' Regulations).

Chemistry	497	287	210	57 per cent.
Pharmacy	197	139	58	70 ,,
Biology	486	327	159	67 ,,
Osteology	467	376	91	80 ,,

Second Conjoint (Five Years' Regulations).

	89	59	30	66 per cent.

Second Conjoint (Four Years' Regulations).

Anatomy	722	438	284	60 per cent.
Physiology	762	438	324	57 ,,

Third Conjoint.

Medicine	869	491	378	56 per cent.
Surgery	843	485	358	57 ,,
Midwifery	859	578	281	67 ,,
Dental Surgery	129	88	41	68 ,,

Volunteer Medical Staff Corps.

A few vacancies are now occurring in this branch of the Volunteer forces which especially appeals to Medical Students. The Corps is on the same footing as the regular M.S.C., and in action is solely occupied in ambulance work. Instruction comprises stretcher, waggon and litter drill, and the transport of wounded by improvised seats; bandaging, first aid, etc., in addition to the company and battalion drill of an ordinary infantry regiment. There is a Shooting Club in connection with the Corps, and matches and prize meetings are arranged in the summer. The Corps goes under canvas at Aldershot in the summer for training, at the M.S.C. Depôt, and is also out at Easter—usually at Netley. The entrance fee is 10s., and there is an annual subscription of 10s. A complete kit and equipment, including great-coat, is issued to every recruit on enrolment for the term of four years.

If a sufficient number of recruits is enrolled, all recruit drills can be done at the Hospital, thus saving the time required in going elsewhere to drill. Men desirous of joining are requested to communicate with Corporal Dixon or Staff-Sergeant Fulham-Turner, from whom any further information respecting the Corps may be obtained.

Volunteer Mess.

The United Mess Dinner will be held on Friday, October 26th, at 7 p.m., at "The Moorgate," Finsbury Pavement. Tickets may be obtained from the Committee:—R. Tilbury Brown, T. Godfrey, H. Fulham-Turner.

Passim.

When Mr. Dunn retired from the post of Demonstrator of Anatomy he was presented with a case of tracheotomy instruments, subscribed for by the students who had worked under him. Writing to his Assistant Demonstrators, he expressed his "great pleasure and gratitude for the present." . . "I do assure you that I most heartily appreciate the attention, and hope you will convey my grateful thanks to your fellow-students." . . "I shall never look upon that case without recalling the many pleasant hours spent amongst you whilst working at anatomy."

Candidates for the Primary and Final Fellowship Examinations are reminded that they should leave their names at the Medical School Office not later than Monday next, in order that schedules may be prepared.

Dental Students who intend presenting themselves at the forthcoming L.D.S. Examination, should bring their L.D.S. schedules to the Medical School Office, with the Certificate of Practical Dentistry signed on, at once.

Thanks to the efforts of Dr. Sophia Jex-Blake, "Dean" of the Edinburgh School of Medicine for Women, henceforth women will be at liberty to matriculate at the Edinburgh University, and to present themselves in due course for medical degrees there, a privilege hitherto only granted to them in the British Isles by the Universities of Ireland, London, and St. Andrews. This is only now accomplished, in spite of the fact that the University Court, so long ago as 1869, decided that facilities ought to be afforded to women for instruction and graduation in medicine. Quoting from the letter of Dr. Sophia Jex-Blake, but recently published in the daily press, we may well "feel that no more felicitous end to the battle could be conceived, and that the women students and the University are equally to be congratulated on this happy termination of a momentous contest."

We are requested to announce that Students who are desirous of becoming members of the Guild of St. Barnabas for Medical Students, which is composed of communicants of the Church of England, should apply for information to the Chaplain, Rev. E. F. Russell, 35, Brooke Street, Holborn, E.C., or to R. A. Walter, Esq., 14, Woburn Square, W.C.

Calendar of Coming Events.

Oct. 20. 1st XV. v. Wickham Park. Home.
2nd XV. v. Streatham A. Away.
1st XI. v. Beckenham. Away.
2nd XI. v. St. Mary's Hospital. Home.
„ 23. Christian Union. Annual Sermon by Rev. Preb. Webb-Peploe in the Hospital Chapel, at 4 p.m.
„ 24. 1st XI. v. Chatham. Away.
2nd XV. v. Royal College of Science. Home.
„ 27. Guy's and St. Thomas's v. Cardiff. Away.
2nd XV. v. Kensington. Home.
1st XI. v. Bexley. Home.
2nd XI. v. R.M.A., Woolwich. Away.
Physical Society. Clinical evening.
„ 29. Guy's and St. Thomas's v. Swansea. Away.
„ 31. 1st XV. v. East Sheen. Home.
2nd XI. v. St. Thomas's Hospital. Home.

Presentation.—Dr. Charles Pollard, on his resignation of the post of assistant medical officer of the St. George's Union Infirmary, which he had held for nearly eight years, has been the recipient of a valuable tea and coffee service from the officers of that establishment, as a testimonial of their regard and esteem.—*Lancet.*

Two Cases of Bony Ankylosis of the Temporo-maxillary Articulation successfully treated by Excision.

Case I.—Edith H., æt 12. When eighteen months old destroyed much of the upper eyelid, producing the deformity visible in the photograph No. 1, and had caused bony she had infective cellulitis of the left cheek, which had ankylosis of the left temporo-maxillary joint with the mouth tightly shut. At the time she came into the Hospital the mandible was remarkably ill-developed, in comparison with the size of the superior maxillary bone, the tips of the lower central incisors being three-quarters of an inch behind the tips of the upper central incisors, in addition they were very long, and bit into the mucous membrane of the roof of the mouth. The second premolars and molars were absent in the lower jaw. She pushed her food into her mouth with her fingers through the interval between the central incisors and the centre of the roof.

On an anæsthetic being given, it became necessary to open the trachea at once, as the tongue blocked the upper aperture and could not be got forwards. Mr. Lane then cut down upon the site of the articulation and found that the zygoma, head, and neck of the mandible were all merged in one mass of bone; he then, with considerable difficulty, resected a piece of the ramus, leaving a gap of about half-an-inch. The wound healed under a single dressing, and movement was encouraged by the use of chewing-gum very soon after the operation. After an interval of a few months the lower jaw was divided vertically to the right of the incisor teeth, and the fragments were united by wire, so that the free margins of the incisors were brought into the line of the adjoining teeth, by which the interval between the open jaws was increased still further by at least a quarter of an inch.

At the end of a year from the first operation she can articulate well, can bite and masticate her food with ease, and can move her lower jaw from the closed position to that shown in photograph No. 2. Photograph No. 1 shows the ankylosed jaw upon admission.

It is worthy of note that such an extreme condition of ill-development of the lower jaw is very rare indeed.

Case II.—Evan W., æt. 4. When a year old he had scarlet fever, after which it was found that he did not move his jaw. Upon admission, the jaws were fixed in the closed position; having no incisors in the upper jaw, however, he was able to pass food into his mouth through the interval between the lower incisors and the upper alveolus. The upper jaw was somewhat overhanging, but there was no marked deficiency in the development of the lower jaw, as in Case I.; due no doubt to the fact that, being so much younger, the bones of the face had not grown to such an extent, and were therefore not large in contrast.

No. 1.

No. 2.

No. 3.

No. 4.

Mr. Lane first exposed the left joint, and found the articulation normal, except for adhesions, which he broke down. The situation of the right joint was then exposed, and, with difficulty, the head and part of the neck, together with the adjacent portion of the temporal bone, were resected and the wound closed up. The wound healed by primary intention, and a few days after the operation he was provided with caramels to chew, and the jaw was opened and closed several times daily until such time as he would do it himself. Three weeks after the operation he could open his mouth to the extent shown in photograph No. 4. Photograph No. 3 shows the mouth closed.

This operation for immobility of the lower jaw, so often attended as it is by recurrence of the ankylosis, is not looked upon as having a very favourable prognosis. This is, at least in some cases, due to the fact that the wound becomes septic; whereas, if the whole operation is carried out under the strictest aseptic precautions, as in the two cases cited, there is no *a priori* reason why the false joint should not remain permanent.

W. C. C. P.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

R. C., Windlesham.—The membranous masses from the specimen sent contain large numbers of catarrhal cells. There were no definite deposits of fibrin. A large number of micro-organisms were present, but no tubercle bacilli were recognised.

E., Eastbourne.—Tubercle bacilli present.

W. H. M., Kidderminster.—The growth is a glio-sarcoma.

F., Oldham.—No tubercle bacilli present.

H., Northampton.—Will report shortly.

C. D. M., Bournemouth.—No tubercle bacilli present.

PATHOLOGIST.

The Physical Society.

A meeting of the Society was held in the Club Smoking Room on October 13th, Mr. D. M. Beddoe, F.R.C.S., in the chair. The minutes of the previous meeting having been read and confirmed, the Chairman called on Mr. Pakes to read his paper on

"DIPHTHERIA."

Mr. President and Gentlemen,—Before coming to the subject of my paper, may I explain what has been my endeavour whilst writing it?

There are so many questions involved in the disease itself, its diagnosis and its treatment; so many points of view from which it may be studied, that it would be obviously impossible, in the time at my disposal, to touch upon them all, except in the most meagre of ways. The disease as a disease, with its symptoms, sequelæ and complications; the increasing immunity, and decreasing mortality with increased age; the history and causes of its epidemics; the increasing prevalence during the autumn; the greater proportion of cases in a rural than an urban population; the manner in which, and the media by which the disease is spread; might each form the subject of a paper. It has seemed to me, therefore, to be wiser to confine myself merely to three points of view:—

1st. The disease itself, especially with regard it its typical symptom—membranous inflammation of the pharynx or larynx; the diseases which produce more or less similar membranes, or which it not infrequently complicates; and the difficulties which beset the pathway of him who endeavours by clinical observation to diagnose the true malady from its imitators.

2nd. The cause of the disease—the bacillus diphtheriæ; its life history and pathogenic properties; and the methods of bacteriological examination which form the basis of a correct diagnosis.

3rd. A few facts and fancies as to treatment.

The terms diphtheria and diphtheritic are often used merely to signify an inflammation which gives rise to a pseudo-membrane, and Germans still use it in this sense. The modern English term—however bad it may be from a derivative point of view—meaning a membranous inflammation caused by a specific bacillus, is certainly very convenient, and in this paper the term "membranous inflammation" will be used for the conditions arising from other causes than this specific bacillus.

Diptheria is an acute infectious disease characterised by a peculiar inflammation of the mouth, pharynx, nose, larynx, prepuce, vulva, or conjunctiva, with the formation of a membrane upon the inflamed surface. Its incubation period lasts for from two to six days, but, from a diagnostic point of view, except other cases are present in the same house or ward, the fact is of little practical importance. The onset of the disease is not at all typical. There may be a rise of temperature as high as 103° or 104°, but a slight rise up to 100° is the rule. There is usually malaise, but this is often very slight. Headache, vomiting and rigors occasionally occur, but are by no means constant symptoms. The pulse is rapid and inclined to be feeble. The face is pallid, the expression somewhat anxious, especially in children and when any dyspnœa is present. The patient very soon loses his strength. The throat becomes sore, but often it is merely a sense of uneasiness rather than pain. (It is not an uncommon occurrence for a mother to bring up her child and say that it "has been out of health for a few days and does not seem to get better." The throat is not complained of, the patient can speak and swallow comfortably, and yet when the throat is examined, as a matter of routine, it is found that perhaps both tonsils are covered with membrane). The tonsils and uvula are swollen and reddened.

Soon the throat becomes covered with a whitish deposit over the previously inflamed area. The greatest possible variations, both as to site and size occur, thus there may only be a very small piece of membrane on one tonsil, or it may cover both tonsils, soft palate, uvula and nasal cavities, and it may even spread on to the hard palate and affect the mucous membrane of the cheeks: instead, it may spread downwards on to the epiglottis and down the larynx and trachea; occasionally the membrane spreads in both directions at once. In many epidemics of this disease, it has been noticed that the first cases have been of a very mild form, and the development of membrane slight, but as the epidemic has increased in extent, it appears to have assumed a more malignant type and the membrane has been more marked, as if the ultimate cause gained in virulence as it passed from throat to throat. In the form termed "Laryngeal," the membrane is frequently entirely absent from the fauces, being localised to the larynx or larynx and trachea.

This membrane can be stripped from the mucous membrane which it covers in distinct layers, leaving a raw surface from which blood oozes at a few points, but a fresh layer is again deposited, sometimes even in a few hours. The membrane, when washed in water, is of a leathery consistence and glistening white appearance. Whilst on the fauces, the albuminous material of which it is chiefly composed is digested by the various putrefactive organisms which infest the mouth, giving rise to gases which lend to the breath by no means a pleasant odour.

The glands on one or both sides of the jaw are inflamed and indurated, but they are not, as a rule, much enlarged.

When the disease affects the nasal cavities, the mucous membrane is swollen, and the inferior turbinated bones and the septum may be covered with an extension of the membrane. The chief feature is, however, the muco-purulent, or thin brownish mucoid secretion which runs from the nostrils, and which may be streaked with blood. Epistaxis is not uncommon.

In the purely laryngeal form, the prominent symptom is generally that of obstruction, especially in children whose air passages are of comparatively small diameter. The diagnosis in case of a child having urgent dyspnœa will generally rest between diphtheria, a foreign body, or laryngismus stridulus. Two very opposite laryngeal conditions may be met with in children: first, a distinct and fairly thick layer of membrane may be accompanied with very little or no dyspnœa; second, a very small piece of membrane, or even the presence of mucus, may cause symptoms so acute that tracheotomy is necessary instanter.

In February of this year, two cases illustrating these conditions were published in the Gazette. A child a few months old, who died presumably of malnutrition, had during life shown no signs of dyspnœa. At the post-mortem a complete ring of membrane was found just under the vocal cords, which was examined and found to be diphtheritic. The converse was a boy of about three years old whose dyspnœa was so pronounced that tracheotomy was considered necessary, and performed; no membrane was ever seen, but shortly after the operation he coughed up a considerable quantity of mucus, and from that time made an uninterrupted recovery. The mucus was carefully examined and cultures were made, but it was not diphtheritic.

Albuminuria is said to occur in about forty per cent. of the cases of diphtheria. When it does occur, it is during the time when the membrane is on the throat, and not later, as in scarlet fever. All that can be said of this symptom is that if it be present in conjunction with a membrane on the throat it probably points to diphtheria, as follicular tonsilitis is not known to give rise to albuminuria. On the other hand, it would be unwise to insist that this conjunction of symptoms always indicates diphtheria, since it is never impossible for a patient suffering from transient or even chronic albuminuria to contract follicular tonsilitis.

It seems to me, therefore, the only symptom upon which reliance can be put is the presence of membrane on the fauces or in the larynx. By way of parenthesis, it might be interesting to note that undoubted cases of diphtheria, not of the laryngeal type, have occurred in which only a stringy layer of mucus was seen on the tonsils, in no manner resembling the usual membrane.

If, therefore, the diagnosis depends upon the presence and character of this membrane, it becomes necessary to find what other causes give rise to a similar condition, and how the two may be diagnosed.

Inhalation of steam, as from the mouth of a kettle, will produce a very marked membranous inflammation, as will also the swallowing of certain corrosives, but the discovery of the accident will be sufficient to clear up the diagnosis. In those cases which have been examined having a traumatic history, the Klebs-Löeffler bacillus has not been discovered.

In follicular tonsilitis, the tonsil is red and swollen, and is seen to be dotted with yellowish spots, which often lie in a more or less abundant secretion of mucus. In more severe cases, the follicular secretion is more abundant, and that between several contiguous follicles runs together, forming what appears to be a distinct membrane. Where the typical isolated spots occur, the diagnosis seems easy, but in actual practice, either they do not very frequently occur, or are often confluent, for as a matter of fact, medical men not seldom send such cases to the fever hospitals as diphtheria. I do not mean to say that it is always or often difficult to distinguish between the two diseases, but I think many here, with far more experience of the disease, will bear me out that there are times when it is impossible; and when this is the case, the patient is signed up as suffering from diphtheria, and the onus of diagnosis is thrown upon the fever hospital authorities.

The disease whose throat symptoms most nearly simulate those of diphtheria is undoubtedly scarlet fever. Dr. Taylor thus speaks of these symptoms:—"In the throat, it is seen that the uvula, soft palate and fauces are deep red, and often slightly œdematous; the tonsils are reddened, swollen, projecting towards the middle line, and presenting a number of yellow points, from the follicles being distended or covered irregularly with ashy or yellowish secretion. In later stages they may suppurate, or sloughs may form in them. The nasal mucous membrane also inflames with the occurrence of much mucous secretion, and the submaxillary and cervical glands become enlarged and tender." This may arise during the stage of pyrexia, before the eruption, or during the eruptive, or during convalescence. When it occurs during the eruptive stage there will be little doubt in the vast majority of cases that it is due to the scarlet fever, but it does occasionally happen that the two diseases do run concurrently, and that the membrane is diphtheritic. As a matter of experience, any form of membrane occurring during the convalescent period is most likely to be diphtheritic. There remains the condition of membrane during the pyrexial stage. As regards this membrane, it is stated to be yellowish rather than white, of less consistence than the diphtheritic, and as peeling off in shreds. These differences, however nice theoretically, are practically so minute as to sink into insignificance. I should like to refer you to a case I saw of membrane occurring during the eruptive stage. A girl of, I think, eighteen had scarlet fever, with a profuse membrane on her tonsils and soft palate. A piece was removed from the left tonsil, which, when washed in water, was *white*, tough and leathery: it was about half-an-inch square, and one-eighth of an inch in thickness. As a matter of course, everybody who saw it was convinced from its clinical appearance that it was a case of the two diseases conjoined. From the membrane seven cultivations were made, and the specimen was hardened and cut. Three kinds of colonies grew, and although no colonies were thought to be diphtheria from the naked-eye inspection, twenty-four of them were examined, but not a single bacillus diphtheriæ was seen. In a fever

hospital it is obviously of very great importance to be able to diagnose to which of the diseases the membrane belongs, as the introduction of a scarlet case into a diphtheria ward would probably be followed with results more disastrous than interesting.

A similar condition of things occurs during or after measles. So far as I have been able to find out, the subject has not been as much worked at as scarlet fever, but those who have studied it have come to the same conclusions as in similar scarlet cases, viz., that, generally, a membrane occurring during the attack of measles *is not*, whereas one occurring during the convalescent period *is*, diphtheria.

There is still another condition of membranous exudation of which I have seen one case. A girl, æt. 19, had a sore throat, with slight pyrexia and no albuminuria. Upon examination, the tonsils were slightly swollen; no spots of yellowish secretion were seen, but upon the left tonsil a thin whitish membrane, of which a portion a quarter of an inch by a sixth of an inch, was removed. She did not develop measles, nor scarlet fever, nor was there any traumatic cause. The concensus of opinion was that it was not follicular tonsilitis, but diphtheria. Four cultivations, in all, were made, and no bacillus diphtheriæ was present. The patient's throat cleared on the third day; albuminuria was never present; she had no sequelæ or complications. So that, as far as our present knowledge goes, there would appear to be an idiopathic form of membranous exudation, in other words, one of which we do not know the cause.

I have not spoken of the peripheral neuritis, which so often follows diphtheria, as it does not interest us from the point of view of diagnosis, and I only mention it now in order to be able to refer to it in the second portion of the paper.

Before leaving this part of the subject, I should like just to refer to the fact that the cat, among the lower animals, appears to be very susceptible to a form of this disease. They suffer from a membranous exudation in the bronchi, very similar to that seen in the human larynx, and from which the bacillus diphtheria can be cultivated. On more than one occasion an epidemic of diphtheria in the human species has been started by its equivalent in cats. *(To be continued.)*

Notice.

STUDENTS' CLUB.

NOTICE IS HEREBY GIVEN, THAT THE
GENERAL MEETING
OF
THE STUDENTS' CLUB

Will be held in the Anatomical Theatre on Friday, October 26th, at 4.15 p.m.; in accordance with Rule 17. Mr. Durham in the chair.

The business to be transacted will be the passing of the audited accounts for the year ending 31st August, 1894.

J. FAWCETT, } Hon. Secs.
Guy's Hospital. H. J. SPON, }

Guy's Hospital.

TREASURER'S REPORT FOR THE YEAR ENDING LADY-DAY, 1894.

(Concluded.)

The prevalence during the past year of scarlet fever, measles, and diphtheria amongst the cases presenting themselves in the Out-Patient Department and Surgery rendered it very expedient to have better means of isolating them whilst waiting for the arrival of the ambulance to take them to Fever Hospitals or to their homes; and accordingly a small room in the Medical Building was set apart for their reception. The apartment has the advantage of being over the boilers of the heating apparatus and is therefore always warm, a matter of no small moment as regards expense when a room is only occasionally in occupation. For noisy and delirious patients the disused part of "Samaritan" ward has been fitted up, and they have been transferred from the old Strong-room in the basement into a lighter and more airy room on the top floor of the Hospital. By the new arrangement the nursing of such cases is placed more directly under proper supervision. To facilitate the summoning of House-Physicians to urgent cases, a telephone has been fitted up to connect "Mary" ward with the College, a speaking-tube being already in use for the same purpose between the other medical wards and the same place. New linoleum has been laid down, at a cost of about £60, in "Accident," "Cornelius" "Lazarus," and "Martha" wards, to replace that generously given by Mr. Bryant and Mr. Durham some years ago. The ceiling of the small dormitory staircase in the Medical Building, which some months ago caught fire, has been reconstructed of concrete. A new lavatory has been provided for the Medical Staff, and the court-yard of Petersham Buildings has been paved with blue bricks. The skylights over the Anatomical and old Materia Medica Museum have been renewed at a cost of about £120, and certain important improvements have been effected in the Mortuary. In these and other matters the Treasurer has had the advantage of the advice of Mr. J. H. T. Woodd, of the firm of Messrs. Woodd & Ainslie, architects, of 35, New Bond Street, who has lately been appointed surveyor to the Hospital.

The number of beds available for patients remains the same as last year, namely 518, of which 45 beds and two cots are reserved for patients who pay an inclusive charge of one guinea a week, and 24 beds for cases in "Bright" ward paying three guineas a week for board and maintenance. It should not be forgotten that besides the 518 beds thus enumerated there are two large wards in the Medical Building unoccupied for want of funds, and these wards, if filled, would accommodate about one hundred patients.

The average number of beds in daily occupation during the year 1893 was 411·3 as against 423·7 in the previous year.

During the last year, 5,764 new cases were admitted to the Hospital as against 5,554 in the previous year. The number of cases remaining in the wards under treatment on January 1st, 1893, was 396, making a total of 6,160, as against 5,969 in the previous year. Of this number, 5,065 were discharged as cured or relieved, and 132 as unrelieved; 546 died, and 417 remained under treatment on January 1st, 1894.

The average number of beds in daily occupation during 1893, was less by 12·4 than in the previous year. This diminution was brought about in a large measure by the greater strictness with which beds reserved for paying patients were kept for that class rather than by any lessening of the demand for accommodation in the wards. Coincidently with the smaller number of beds in daily occupation, there has been a diminution of the mean residence of each patient from 27·7 days to 26·1 days, and thus, though fewer beds were in daily occupation, more patients passed through the Hospital. This more rapid circulation was rendered possible by the greater facilities now obtaining for the despatch of patients to convalescent homes. No less than 433 cases were thus assisted by the Samaritan Fund, as against 277 in the year 1892. It is unnecessary in this place to enter into detail as to the work of this valuable agency, as a separate account is published of its scope and operation. The average mortality amongst patients of all classes has been 8·8 per cent., which is lower than in any previous year, except in 1890, when the same small percentage obtained.

Separating the accident cases admitted into the wards from the total number of surgical in-patients, we find that during the past year 908 cases out of a total of 3,623 were due to accident. The number of deaths amongst these cases amounted to 70.

For the purpose of ascertaining the cost of each bed occupied and of each in-patient, the total expenditure of the Hospital for the year (£41,659) has been taken, deducting from it all extraordinary expenses (£2,196), expenses on School Buildings (£371), and charges under the Founder's Will (£925); and further deducting one shilling and sixpence for every out-patient and maternity case (£4,262). Dental out-patients have not been reckoned, inasmuch as none of the cost of treating them falls on the Hospital, such charges being borne to a large extent by the patients themselves, and the deficiency being made good from the funds of the Dental School. During the year ended August 31st, 1893, the expenses of the Dental Department under this head amounted to £706 6s. 3d., the receipts from patients being £354 17s. 11d.

The average stay of patients in the Hospital is about 26 days, the cost of each patient per week is about £1 12s.

Turning now to the Out-Patient Department we find that there has been a considerable increase in the number of patients seen by the Assistant Physicians and Surgeons, the House Physicians and Surgeons, and the Staff of the Special Departments. The following table makes these facts clear:—

		Last Year.
Medical Out-Patients	8,584 ...	7,853
Surgical Out-Patients	6,209 ...	5,555
Diseases of Women	2,184 ...	2,026
Diseases of the Skin	2,296 ...	2,147
Diseases of the Ear	1,007 ...	874
Diseases of the Eye	2,737 ...	2,863
Diseases of the Throat	533 ...	517
Total	23,550 ...	21,835

It should, however, be added that renewals of letters are here reckoned as new cases. The letters supplied to the patients seen and prescribed for by the Visiting Staff are available for eight weeks, those supplied to the patients of the House Physicians and Surgeons for four weeks, the latter class consisting of patients who are suffering from less serious diseases, for which a month's attendance is usually sufficient.

The number of women attended in their confinements by the Lying-in Charity last year was 3,188, which is the highest number yet recorded. In addition to the assistance afforded them by the Obstetric Physicians and Extern Attendants, the mothers have for the last four years enjoyed the advantages of the services of two Maternity Nurses supported out of the earnings of the Nurses upon the Guy's Hospital Private Nursing Staff. As the state of poverty in which many of these poor women are discovered is very deplorable, and they are often found to be destitute of the most common necessaries of life, a Maternity Samaritan Fund has been established, and contributions for it will be gladly received by Miss Sarah A. Swift, the Lady Superintendent of the Trained Nurses' Institution, 12, St. Thomas's Street, London, S.E. Miss Swift will be happy to send to any one wishing for it the Report of the Institution, in which full details are given of the work of the Fund.

The Casualty Cases, under which head are included minor accidents and medical cases not serious enough to require attention in the Out-Patient Department, numbered 30,094, being an increase of 4,229 upon the total of last year.

The large increase in the number of casualties since 1890 (then 19,469) is probably to be accounted for by the changes in the system of appointments introduced in that year, whereby patients applying for relief in the surgery are seen and treated with more expedition than in preceding years. In fact, experience teaches that so soon as in any Out-Patient Department measures are taken to ensure that applicants shall be seen without delay, the numbers at once begin to rise, and thus the object aimed at becomes increasingly difficult of attainment.

The activity of the Dental Department has been well maintained, and the success of the School has been continuous. The Managers of the Hospital Saturday Fund have sent no less than 220 dental patients to the Hospital under the arrangement by which each case is treated at a cost to the Fund of half-a-crown.

INCOME AND EXPENDITURE.

The Abstract of Accounts subjoined to this year's Report is for the second time compiled in accordance with the uniform system of accounts recommended for adoption by the authorities of the Hospital Saturday and Sunday Funds.

In briefly commenting upon the various items, the Treasurer desires first and foremost to call attention to the fact that the Rental from Estates during the past year has dropped to £21,005, which point is the lowest hitherto reached. The greatness of the fall in values may be gauged by the single statement that in the year 1880 the income from these same estates reached £40,000. It thus appears that the rental for 1893-4 is only a little more than half what it was fourteen years ago, and the present financial position of the Hospital is a very grave one.

The award of the Hospital Sunday Fund this year has been £425, as against £550 in the previous year, and of the Saturday Fund £577, as against £586 in the year 1892. The congregation of St. Andrew's, Stoke Newington, has through the Vicar, the Rev. H. E. J. Bevan, Gresham Professor of Divinity, contributed this year no less than £100 to the Hospital, making in all a total of £535 received from this source.

There is a diminution of about £130 in the receipts derived from paying Probationers, who are known at Guy's under the name of Lady Pupils. On the other hand, the receipts from paying patients amount to £3,511, as against £2,958 in 1893. There is an increase of about £200 on "Bright" patients, and of about £350 on paying patients in the general wards, this latter increase being due in great measure to the large number of typhoid cases sent into the Hospital at one guinea a week by the Metropolitan Asylums Board.

The net income of the Institution available for Hospital purposes during the year 1893-4 was £27,788, as against £32,704 in the previous year, and the deficiency made up from the Special Appeal Fund was no less than £8,473.

THE SPECIAL APPEAL FUND.

The Special Appeal Fund stood on Lady-Day, 1893, at £109,075 12s. 10d., which sum is exclusive of the sums (amounting in all to about £21,000) received during the last seven years from the Hospital Saturday and Sunday Funds, and from interest. During the last twelve months the sum of £2,880 15s. 11d. has been added to the Fund. The largest donation during the past year was that of an anonymous subscriber, a lady, who gave £500, which donation was duly acknowledged in the public press.

The fact that it has been necessary to supplement the income of the Hospital by a sum of no less than £8,473 15s. 6d. from the Special Appeal Fund shows the continued necessity of calling upon the charitable public for assistance in carrying on the work of this great Hospital. Situated as Guy's is, in the midst of one of the poorest districts of London, it would be no less than calamitous, were it found necessary to contract still further its sphere of activity by the closure of more wards; and it is only by legacies and by continuous support from the benevolent, that the present number of beds can be kept at the service of the sick and suffering. Donations and yearly subscriptions will be gladly received, and should be sent to the Treasurer, at the Counting House, Guy's Hospital, London, S.E.

E. H. LUSHINGTON, Treasurer.

June 18th, 1894.

Pass List.

Second Conjoint Examination, Oct., 1894.

(Under the 4 years' Regulations.)

ANATOMY AND PHYSIOLOGY.

Stamford, R. B.

ANATOMY ONLY.

Rowland, R. S. Treusch, J. B. A.
Vick, T. J.

PHYSIOLOGY ONLY.

Crosby, A. E. B. Parsons, J. E. H.
Longhurst, S. H. Pearson, G. B.
Ponsonby, J.

(Under Regulations dated January 1st, 1892).

ANATOMY AND PHYSIOLOGY.

Jones, J. H. Owsley, G. Chetwode
Way, M. H.

First Conjoint Examination, October, 1894.

(Under the 4 years' Regulations).

ELEMENTARY ANATOMY AND PHYSIOLOGY.

Cogan, L.D.B.

CHEMISTRY AND PHYSICS.

Ashby, E.

MATERIA MEDICA AND PHARMACY.

Cogan, L.D.B. Finch, A. H.
Davies, T. Payne, J. L.

(Under Regulations dated January 1st, 1892).

ELEMENTARY ANATOMY.

Jensen, E. T., Tongue, E. J.,
Ward, P. H.

ELEMENTARY BIOLOGY.

Crew, E. J.

PRACTICAL PHARMACY.

Jensen, E. T., Moss, B. W.,
Smith, J. N.

University of Durham.

(Examination for the Degree of Doctor in Medicine for Practitioners of 15 years' standing).

A. Kinsey-Morgan, M.R.C.S., L.S.A.

Guy's Hospital Debating Society.

The fifteenth meeting of this Society, and its first as a constituent institution of the Clubs' Union, was held in the Smoking Room on the 6th inst. Dr. Pavy, President, occupied the chair, and there was a fairly-full house, including Dr. Shaw, Mr. Dunn, Dr. Fawcett, and about fifty members.

The Chairman, in the course of a few introductory remarks, heartily congratulated the Society on its having satisfactorily passed through the probationary period and taken its place as a constituent institution of the Clubs' Union. He reminded those present that reading made the *full* man, writing the *correct* man, and speaking the *ready* man; and said that there was to his mind something significant in the fact of the Debating Society being sandwiched in the list of constituent institutions between the Cricket and Football Clubs. Important as was the exercise of the limbs, it would be of greater importance still to the student when he went into practice that he should have learnt how to use his tongue and to express his thoughts clearly. He then called upon Mr. A. P. Allan to read his paper on "What has become of the Liberals?"

Mr. Allan remarked on the change that has taken place of late years, viz., the disappearance of Liberals from the middle-classes of London and its environs, and then went on to account for the new state of things. After sketching types of what the introducer considered representative of suburban politicians, he accounted for the change by remarking that a Liberal with fundamental principles is such a *rara avis* that any slight shock will often turn the politics of the ordinary Liberal. Conservatism was also observed to set in with atheroma —to take place in the middle-age, independent of other causes, save the state of the tissues. The reader then dealt with the young men. They were Conservative, he held, because the particular measures now advocated by the Liberals affected them so little personally, whereas formerly the Bills introduced dealt with vital questions touching their class. But the great change has been brought about, according to Mr. Allan, by the hysterical condition of the present-day individual, who is in dread of every measure introduced into Parliament, and unable to take a calm survey, stamps all new departures as spoliation, robbery, devastation, and disintegration. Mr. Allan then quoted numerous instances culled from history, showing how that the harmless privileges we now enjoy were all in their day regarded by their opponents as revolutionary. A further cause of middle-class Conservatism was, we were told, the ignorance shown by that class of the aims and aspirations of working people, Mr. Allan instancing that we find people condemning as rogues and fools that very artizan class which has placed England where she is as chief of the world's manufacturers, or that we find respectable people, who sit at home regarding as entirely lacking in patriotism that class which has furnished those soldiers and sailors by whom our great victories have been achieved. Finally, Mr. Allan remarked that a great many people preferred to throw in their lot with the party to whom the aristocrats belonged, out of a snobbish desire to be genteel. He then proceeded to remark on the new departure in the Conservative party which a subsequent speaker termed "Tory democracy," leading to a levelling of the two parties, and so attracting some persons from the Liberal ranks. Mr. Allan confined his remarks to the Liberals of "the Home Counties" and London—a fact which several subsequent speakers seemed to have misunderstood. Mr. Allan ignored the "wealth-factor" influencing politics, apart from what he termed the general nervousness of the times—nor was this assertion challenged by any subsequent speakers.

The conclusion of the paper was succeeded by a long pause, broken at last by

Mr. R. O. Moon, who gave a general support to Mr. Allan's opinions, but had hoped to hear the views of the other side of the House. This brought up

Mr. Ham, who in a mild but caustic manner ridiculed the position, the programme and the constitution of the Liberal party.

Mr. Spriggs thought the change in the popular attitude towards the Liberals in a large measure due to the reaction which followed the close of the Session.

Mr. Pakes admitted that the old Tory party had faded in company with the old Whigs, but asserted that the Conservatives of to-day were essentially democratic and a party of progress; while

Mr. Parry was as vehement in his belief that everything the Tories did in the interest of the country was cribbed from the Liberal programme.

Mr. Reaside, in a vigorous and convincing speech, was really the first to hit the mark in the debate, which hitherto had been rather pointless. He was far from assured that Mr. Allan in his paper had shown them what had become of the Liberals or to what their present position was due; in fact, the paper had degenerated into a very ordinary attack on the Conservative party, which, having grown while Liberals were disappearing, was entitled, on the principle of the survival of the fittest, to thoughtful respect. It was surely dangerous for so eminently respectable a gentleman as Mr. Allan to sneer at respectability as a mark of Toryism. In the speaker's opinion, the disappearance of the old Liberals, to whom Mr. Allan seemed to belong, was due to the discredit which had fallen upon their principles of individualism. Their work had been to obtain for the individual, freedom to climb the ladder of prosperity, and the right of the individual to keep the fruits of his skill and perseverance for himself followed without question. On the other hand, the socialism of the day demanded that the wealth won by the efforts of the individual should be shared by all. Whatever the merits of the principles held by the Liberals whom Mr. Allan appeared to represent, they were clearly out of joint with the times, and it was not by them that the conglomeration of what was known as the Liberal party to-day fashioned its course.

The discussion was continued by Mr. Hamblin Smith, whose remarks as a "Young Tory" were well received; Mr. Passmore, Mr. E. Coleman and Mr. B. A. Richmond, and the proceedings closed with a vote of thanks to Dr. Pavy. No resolution having been proposed, the joys of a division were denied; but we understand that a very sharply-defined issue will be presented at the next meeting.

Sport.

Rugby Football.

GUY'S v. ROSSLYN PARK.

The opening match of the season, played on October 6th, was won by the Hospital by a placed goal (five points) from a try by Rae, to a dropped goal (four points).

GUY'S & St. THOMAS' (Combined) v. BLACKHEATH.

Played on October 13th, and after a grandly-contested game, chiefly confined to the forwards, ended in a draw, each side scoring a try. The Hospitals were without K. B. Alexander, Rotherham and Hancock.

GUY'S v. CAMBRIDGE UNIVERSITY.

Played on October 17th. Guy's were somewhat crushingly defeated by five tries (fifteen points) to nil. The Hospital had not its strongest team, being without the services of Hancock (who has not yet recovered from his accident sustained when playing against Rosslyn Park), Nicholson and Stewart.

GUY'S 2nd XV. v. BROCKLEY.

Played on our ground on Saturday, October 13th, resulting in a thoroughly well-deserved victory for the visitors by three goals (one dropped) to nil. Tries by Haines, goals by Moore. Of the game nothing need be said. Our men were out-played from start to finish, at every point of the game, and of the hour of play the ball was out of Guy's territory for about ten minutes, all told. Walling was fairly good at times, but frequently failed to take the ball at the first attempt, and so let his opponents rush on him before he could do anything useful. The three-quarters were disappointing, their passing and tackling being simply execrable (with the exception of a few occasions when Morgan put his man down), while the two centres invariably ran their wings right on to the touch line before passing, and seemed to prefer to make futile attempts at intercepting the opposing three-quarters' passes, to looking after their respective men and stopping them. The halves were the most useful men on the side as regards tackling, but their passing and management of the scrums was poor, Kevern being the worse of the two in this respect. The injury to his finger is most deplorable, as, with all his faults, he is far away the best half the second fifteen seem likely to get. As to the forwards, nothing can be said in praise. They held their own pretty well as far as shoving was concerned, but unfortunately, nearly always managed to shove away from the ball; when they managed to get this desirable acquisition among their feet, they placed it carefully to the opposing half when near their own goal-line, while on rare occasions, when they were attacking, they kept it in the second row for a time that seemed an eternity, and then hacked it out to somewhere between the three-quarters and back, when, as generally happened, the Brockley men got the ball by smartly following up; our men continued to shove until the ball had been handed to the opposing three-quarters, and had been carried beyond our halves. Not once in the whole course of the game could a single man be seen following up a kick at any pace beyond a mild jog trot. In fact, it may fairly be said (and was said by more than one or two on the ground), if that game is an example of the way the second fifteen are going to play this year, they won't win a solitary match. Team:—

Guy's.—H. Walling (back); Dowsett, A. C. Ransford, T. Morgan, H. W. P. Barrow (three-quarters); J. T. Kevern, H. T. Hicks (half-backs); A. J. Cleveland, N. H. Pike, W. Tyson, P. D. Hunter, M. D. Wood, J. M. Gardiner, W. J. Lindsay, E. G. Goddard (forwards).

Association Football.

GUY'S 1st XI. v. WESTMINSTER.

Our opponents turned up with eight men, and kept us waiting until four o'clock for the others. The ground was in splendid condition, and the game was fairly fast in the first half, though mostly in our favour. In the second half, our opponents were chiefly on the defensive, and we ran out easy winners by five goals to one—Pearson, 2; Davis, 2; Palmer, 1. There were only three of last year's Cup team playing, and some of the new men promise very well. When in better condition, and with more combination, the team should turn out a strong one. Team:—

Guy's.—M. S. Barker (goal); H. Goadby, F. J. Lidderdale (backs); A. E. Crosby, E. J. Crew, F. E. Walker (half-backs); C. S. Brookhouse, A. Pearson, E. J. Davis, W. G. Palmer, P. S. Mandy (forwards).

Appointment.

Godson, J. H., M.B., B.S., has been appointed Medical Officer of Health of the Cheadle and Gatley Urban Sanitary District, *vice* A. Godson, resigned.

Births.

KEMP.—On October 9th, at Worksop, Notts, the wife of G. Lajus Kemp, M.B. Lond., of a daughter.

PENNELL.—On October 4th, at Lomas di Zamora, Buenos Ayres, the wife of G. H. Pennell, M.D., F.R.C.S., of a daughter.

RAKE.—On September 30th, at "St. Ives," Fordingbridge, Hants, the wife of Herbert V. Rake, M.R.C.S. Eng., L.S.A., of a son (Louis Stansfield Reynolds).

SMALLPEICE.—On October 1st, at Queen Anne's Gate, the wife of William Donald Smallpeice, L.R.C.P. Lond., of a

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* MR. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

NOVEMBER 3, 1894.

Pyæmia.

CLINICAL LECTURE BY DR. F. TAYLOR.

PATIENT was a foreman, æt. 44, and was admitted on October 12th for pyrexia and delirium. There was nothing of interest or importance in his previous history beyond the facts that he had been a hard drinker for years, and had not had acute rheumatism. The present illness began on October 5th (six days before admission), with headache and pains in the right arm; and although lassitude and disinclination for exertion were marked symptoms, he was able to go to work as usual. On October 6th he was distinctly worse, and he felt considerable difficulty in continuing at work. He was sick the same evening, and sweated profusely, but had no rigor. Profound weakness and depression compelled him to take to bed, and next day, the 7th, he was delirious. He remained in bed under treatment until the 12th, when he was sent up to the Hospital as "right pneumonia and bilious fever." Violent delirium, constipation, and severe pyrexia were the prominent features of his illness prior to admission.

On admission, at 4 p.m., October 12th, the temperature was 104, pulse 110, respirations 40. Patient was a strong muscular man; flushed; with moist skin; no pain or headache; no cough or cyanosis; no exanthema and no optic neuritis. Marked tremor about lips, tongue, and hands, and frequent twitchings of eyebrows and muscles of angles of mouth. Strong, full pulse; apex internal to nipple but slightly outside usual position; soft systolic bruit at impulse. Respiratory apparatus normal, except for some slightly deficient entry of air about the sixth to ninth ribs in front on the right side. No noticeable feature about the abdomen. At 11 p.m. the same evening the temperature went up to nearly 105°, and patient became incoherent and restless, and a soft to-and-fro bruit was discovered, audible only over the fourth rib, 1 to 1½ inch internal to the nipple. Patient was put on Mist. Quininæ ʒi.ss. 4tis horis; and a mixture of Pot. Bromid. gr.xx. and ℞ Hyoscyami ʒss. as a sedative. He was sponged every four hours during the night, but the temperature remained practically stationary at 104·6°. During the six hours from 10 a.m. to 4 p.m. on October 13th, he became much worse in every respect, and the cardiac impulse gradually moved outwards, until it was fully 1½ inch outside nipple. The systolic apical murmur became harsher, the to-and-fro bruit audible over a wider area, and the second sound in the pulmonary area, which hitherto had been sharp and clicking in character, was replaced by a soft diastolic whiff. Consonating râles were now audible at both bases behind, but were limited to the neighbourhood of the spine, and did not extend farther outwards than 1½ inch from the middle line. At 10.30 p.m. the respiration became very irregular; at 11 p.m. a rhythm was noticeable in the respiratory movements, resembling somewhat Cheyne-Stokes' breathing; and 12 p.m. the patient became semi-comatose with the typical Cheyne-Stokes cycle. On October 14th the temperature fell to 100; the patient was sweating profusely, and several patches of erythema appeared on the surface of the body. He had emaciated noticeably since admission. There was now absence of breath-sounds at the extreme right base behind, with consonating râles for some distance above. He was complaining of great pain in the right thigh, and this, on examination, was found to be excruciatingly tender and œdematous; and the skin over the lower two-thirds was reddened and mottled. He had casually mentioned on the previous day that his leg was painful, but no swelling or œdema as compared with the opposite limb could be detected. At 11.30 a.m. Mr. Symonds saw the patient with Dr. Taylor, and he thought that probably there was some deep-seated pus in contact with the bone, and that immediate exploration was indicated. An anæsthetic was given, and two incisions were made on the outer side of thigh, about five inches above the knee-joint, along the outer edge of the rectus femoris. The tissues were boggy and œdematous, but no purulent collection was found, and the finger, passed right down to the femur, felt the periosteum to be healthy. At 6.30 p.m. there was acute effusion into the right knee-joint, which was smooth and red, with obliteration of all bony prominences around. On October 15th the general condition remained much the same, but the patient was obviously getting weaker, and œdema had spread up the

thigh as high as the great trochanter. A faint rub was heard in the morning over the seventh right rib in the anterior axilliary line; and in the evening there was absolute dulness behind at the right base up to the ninth rib, with total absence of breath-sounds and tactile vocal fremitus. For an inch or so above this dull area, resonance and breath-sounds were impaired. Drs. Taylor and Perry saw him about 10.30 p.m., and thought there were some fluid in the right chest. Urine now contained albumin and sugar. On the 16th his condition was typically septicæmic, with low muttering delirium, tremors, subsultus, and very rapid respirations (52–60). Later in the day he became dusky and livid, with uncountable pulse, and at 12 a.m. he had a rigor (temperature 103°), the first and only one of his illness. Cyanosis increased, but there was a temporary rally with ether injections and oxygen inhalations. Though perceptibly sinking, he lived on till 5 p.m. on the 17th, dulness on right side increasing, and râles and bronchial breathing being audible up to the sixth rib in front.

At the autopsy, six ounces of pus were found in the right knee-joint, and two in the right hip; and the right rectus femoris and vastus externus were infiltrated with purulent matter, with a definite abscess in the fascial planes on the outer side. There were similar abscesses in the muscles on the anterior aspect of the right forearm, in the right pectoralis major, around the larynx and hyoid; and on each side of the neck pus infiltrated the connective tissue around the internal jugular veins, burrowing down into the mediastinum. There were a few petechiæ on all the serous membranes; the spleen was large and soft. Right lung collapsed, posterior part and base airless, and sinking in water, with a slight patch of recent pleurisy anteriorly. The heart weighed fourteen ounces, and there was slight dilatation of the left ventricle. Endocardium thickened with minute recent granulations; old mitral and aortic incompetence, the anterior and left posterior aortic valves being retroverted; brain, kidneys, and liver healthy. Ears, prostate, nose, rectum, urethra, tonsils, and larynx healthy. No recent scars or wounds on the surface of the body.

This man came in, as you have heard, on the eighth day of his illness, with feverishness, and he was said by his medical man to have pneumonia and bilious fever. The case, as it then stood, presented certain difficulties in the way of a diagnosis.

Typhoid fever was first considered, chiefly because this is a disease which may, and often does present no characteristic signs—such as the presence of spots on the abdomen, in association with diarrhœa—until the seventh or eighth day of illness, or even later. Diarrhœa is a symptom of the disease upon which too much reliance must not be placed, that is to say, its absence does not prove that the disease is not typhoid fever. Moreover, there were no spots on this man's abdomen, but owing to the prevalence of the disease in London, coupled with the fact that it is difficult to diagnose typhoid when the case is first seen, it was impossible for us to neglect its consideration here.

Influenza, which was next discussed, is a disease which has received marked attention since its occurrence here in 1890. It, however, usually runs a short course, though it occasionally is prolonged until the eighth or ninth day; it is associated with headache, pains about the limbs and back, without any specially characteristic signs in a great many cases.

Malignant endocarditis, not uncommonly confounded with typhoid fever, was fully dealt with, and rightly, for the man was found to have an aortic murmur, which varied from time to time. The only indications of this disease may be in the presence of cardiac murmurs which change in character, accompanied by febrile disturbances.

Malignant endocarditis means that the tissue of the inflamed cardiac valves becomes softened and breaks down, erosions and ulcerations take place which are dependent on the presence of micrococci, and fibrin is deposited forming irregular masses of vegetations. The most important effect is the infection of the whole arterial system by particles detached from the valves and carried to remote parts. These particles become impacted in the arteries, giving rise to embolisms, the parts most frequently affected being the vessels of the spleen, kidneys, and brain, and the vessels of the limbs, such as the radial, tibial, and brachial. This patient was carefully examined, as you have heard, for signs of embolism, but without success. Embolism may obviously lead to gangrene, but not necessarily, and what you have rather to look for is the absence of pulsation in one or more vessels as the evidence that such vessel is blocked by an embolus. Malignant endocarditis may be set up by any source for the introduction of septic matter, producing a kind of arterial pyæmia. Undoutedly it sometimes occurs from a wound or even a scratch, from boils, and from internal lesions; but no such source was found here.

Pyæmia produces somewhat the same kind of symptoms that were noted here, and when the man's thigh was found to be swelling, pyæmia was suggested as the correct diagnosis. For pyæmia often originates from some severe lesion of the periosteum of the bone, from osteo-myelitis or acute ostitis. In ordinary, or wound pyæmia, the pathological lesions met with are abscesses chiefly occurring in the bases of the lungs. In osteomyelitis you will find these abscesses more often situated in the cardiac muscle, and in the kidneys.

I may mention here the case of a boy who was in John ward, in 1888, with pronounced dyspnœa, and physical signs of fluid in the right chest. In addition, it was noticed that during inspiration there was retraction of the fifth right intercostal space, and if he held his breath in expiration, the skin over the rib was distended, as if by air. Aspiration produced nineteen ounces of blood-stained serum. Subsequently crepitus was felt on manipulating the rib, and death took place shortly after. The duration of his illness was apparently only eight or nine days. At the post-mortem there was found acute necrosis of the sixth rib, which was bare from end to end, and

separated from the cartilage. The right lung was compressed, and thirteen ounces of pus lay in the pleura; there was recent pericarditis and broncho-pneumonia of the left lung.

However, nothing very definite was revealed by Mr. Symonds' examination and exploration of the thigh, but at the post-mortem examination we saw that the case finally resolved itself into one of pyæmia, as shown by the suppuration in the joints and between the muscles. Careful search was made for any centre from which the pyæmia might have originated, but nothing was found. The ears were examined—for unchecked middle ear disease often causes pyæmia—and the nose and throat were searched. The prostate and rectum also received careful attention. I remember the case of a man who was being treated for gonorrhœa, in Samaritan ward some years ago, who subsequently died of pyæmia. At the post-mortem there was found suppuration of the prostate, which was the cause of the pyæmia, and malignant endocarditis. The latter had been shown during life by the presence of a double basic murmur, which turned out to be due to acute pulmonary endocarditis—a condition of great rarity.

It is not, however, uncommon also to meet with fatal cases of pyæmia in which no primary source of infection is discovered.

What is *pyæmia?* It originally meant "pus in the blood"; but the following definition which I have obtained from the article by Mr. Warrington Howard, in Quain's *Dictionary of Medicine*, may be accepted as the modern view of the disease:—

"Pyæmia is a condition of blood poisoning which gives rise to fever, accompanied either by severe visceral inflammation and congestions, or by certain local lesions which are chiefly venous thrombosis, embolic abscesses in the viscera, acute suppurations of the venous membranes and joints, multiple abscesses in the connective tissue and eruptions upon the skin. The viscera is usually, but not always, sequential to a wound or injury."

There are several kinds of pyæmia, which may be classified somewhat as follows:—

1. *Ordinary acute pyæmia*, which was of frequent and ordinary occurrence in the pre-antiseptic days of surgery. It gives rise to characteristic symptoms:—rigors, profuse sweating, fever, rapid emaciation in a few days, while the patient is sallow and often jaundiced. Associated with it, abscesses occur in the bases of the lungs, and there may be acute pleurisy, pericarditis and peritonitis. In our case there was no rigor until just before his death; but he rapidly emaciated.

2. *Chronic joint pyæmia.*—Here the viscera are mostly spared; but abscesses form in the subcutaneous tissues, and the joints inflame and suppurate.

3. The pyæmia of *acute necrosis.*—In this form there is a special liability to the occurrence of small abscesses in the heart muscles and in the kidneys.

4. *Portal pyæmia*, in which abscesses occur in the liver with or without suppurative pylephlebitis.

5. The suppuration which takes place in the kidneys as a result of cystitis, is perhaps scarcely a pyæmia; it is rather a local infection, not promoted by the vessels.

6. *Gonorrhœal synovitis* and *scarlatinal synovitis* are probably forms of pyæmic infection.

7. *Malignant endocarditis* is a condition which has been termed *arterial pyæmia*, and the relations existing between it and ordinary acute pyæmia are very close. For instance, two forms are described—the typhoid and the pyæmic; amongst the latter are some cases of pyæmia in which the septic material has attacked the valves of the heart. Conversely, malignant endocarditis allows the distribution of septic matter all over the body, and thus may readily be itself the source of what is practically a pyæmia. It was possible that the mischief about the thigh in the case we are considering was the result of malignant endocarditis; or again, it seemed as if the affection of the thigh might have caused a malignant endocarditis. However, as the post-mortem proved, the cardiac murmurs were found to be due rather to the retroverted condition of the valves from old cardiac disease, than to the minute collection of vegetations upon them, which were thought to be quite recent. We must, however, admit that this particular case did not conform strictly to any one form of pyæmia, but was rather a mixture of the first two groups.

What is the *treatment* of such a case as ours? Quinine, though largely used, cannot be of much avail in the doses we adopted, namely, three grains every four hours. On the other hand, I do not think it can be said it has any specific effect in pyæmia, even in much larger doses. Sulpho-carbolates and benzoates, especially of ammonium, have been used with little, if any, success in allied cases. Nourishment and stimulants should be freely given.

I may here say a few words about the general use of antipyretics. Patients' friends know that we attach a good deal of importance to rise of temperature; and they know further, that the temperature can mostly be reduced by certain antipyretic drugs. They are very apt to look upon the performances of the temperature as the sole indication of the condition of health of the patient. If the temperature rises half a degree, they are anxious; if it falls the same, they are pleased, or even elated. They are consequently rather liable to demand from the doctor that he shall give antipyretics to reduce the temperature, and thus are apt to put a pressure upon him in the treatment of the case which may be distinctly detrimental. If temperature is of importance, it is so more from a diagnostic than from a prognostic point of view. There are very few cases indeed in which the temperature will rise to a height immediately dangerous in itself. The hyper-pyrexia of acute rheumatism is one of these. With great rarity in a few other diseases the temperature may rise to a dangerous height; but then often it is only as a death-phenomenon, and not itself determining the fatal result. In the vast majority of cases in which the temperature rises very high, it will fall again very shortly, and the effects of antipyretic drugs can be got by a little patience without them. If,

on the other hand, they be used freely, and whenever a moderate rise takes place, it becomes very difficult for the doctor to know what is the natural course of his illness, and his knowledge, whether of the diagnosis or prognosis, may be considerably obscured. Undoubtedly the comfort of the patient may be a good deal increased by judicious sponging, and the occasional use of drugs, but these remedies must be used with judgment, and not as a mere matter of blind routine.

I have something to say also of the *Cheyne-Stokes' respiration*, which you may remember this man showed shortly before his death. The exact cause of the phenomenon is not known, but most probably it is due to some disorder of the respiratory centre, whereby it fails to perform its normal functions. The conditions with which it is commonly associated are the following:—

1. Aortic disease and aneurysm of the aorta.

2. Cerebral cases, *e.g.*, meningitis, apoplexy, and cerebral tumour.

3. Fevers, *e.g.*, typhoid, typhus, and others in which the virus acts, as we well know from other symptoms, upon the intra-cranial centres, as it does on other organs. Our case falls within this third group of associations.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Philip	1.	Aortic stenosis and regurgitation. Mitral regurgitation.
	8, 13.	Thoracic aneurysm. Bronchitis.
	24.	Adherent pericardium. Mitral regurgitation.
Stephen	3.	Mitral stenosis and regurgitation.
	6, 16.	Mitral regurgitation.
	18.	Mitral stenosis and regurgitation.
	25.	Mitral stenosis and regurgitation. Aortic regurgitation.
Mary	7.	Aortic and mitral regurgitation.
	8.	Mitral regurgitation.
	11.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	16.	Ulcerative endocarditis.
	19.	Pericarditis. Aortic and mitral regurgitation.
	25.	Aortic and mitral regurgitation. Chronic tubal nephritis. Albuminuric retinitis.
	30.	Chlorosis.
	49.	Mitral and tricuspid regurgitation.

Nervous System.

Philip	5.	Malarial neuritis.
	6.	Vertigo.
	11.	Paraplegia following injury.
	14.	Epilepsy.
	29.	Sciatica.
Stephen	9.	Paraplegia. Spinal caries.
	12.	Cerebral tumour. Optic atrophy.
	17.	Paraplegia. Myelitis.
	21.	Peripheral neuritis.
Mary	12.	Cerebellar tumour. Optic neuritis.
	14.	Hysteria.
	31, 40.	Chorea.
	32.	Paraplegia. Second malignant growth.

Alimentary System.

Abdomen.

Philip	3.	Enlarged liver and spleen. Œdema of legs. Obstruction of inferior vena cava.
	4.	Vomiting. Malaria.
	12.	Hæmatemesis. Cirrhosis of liver. Pleurisy.
	27.	Perityphlitis.
	35.	Ascites. Cirrhosis of liver.
	39.	Carcinoma of stomach.
Mary	1, 2, 46.	Gastric ulcer.
	6.	Abdominal tumour.
	21.	Enlarged spleen. Anæmia.
	23.	? Carcinoma of stomach.
	24.	Neurotic dyspepsia.
	37.	Ascites. ? Cirrhosis.
	38.	Stricture of Œsophagus.

Typhoid Fever.

Philip	9, 34.
Stephen	19, 34, 37, 38.
Mary	18, 20, 35, 36, 45, 50.

Genito-Urinary System.

Philip	18.	Chronic tubal nephritis.
	22.	Diabetes mellitus. Phthisis.
	23, 26.	Tubal nephritis.
	28.	Hæmaturia. ? Renal calculus.
	38.	Tubal nephritis.
Stephen	13.	Œdema of legs. ? Nephritis.
	26.	Chronic interstitial nephritis.
	40.	Chronic tubal nephritis.
Mary	5.	Chronic nephritis.
	22.	Chronic nephritis. Hypertrophied and dilated heart.
	34.	Diabetes mellitus.
	43.	Chronic nephritis. Ascites.

Respiratory System.

Philip	16.	Foreign body in bronchus. Destructive pneumonia.
	23.	Acute bronchitis.
	33.	Empyema.
Stephen	2.	Empyema.
	14.	Empyema.
	22.	Lobar pneumonia.
	27.	Acute laryngitis.
Mary	25.	Broncho-pneumonia.

Phthisis.

Philip	40.
Stephen	23, 28.
Mary	3, 17, 41.

Miscellaneous.

Philip	7.	Anæmia. ? Tubercle.
Stephen	4.	Pigmentation of skin. ? Addison. ? Pernicious anæmia. ? Arsenical.
	32.	? Ulcerative colitis. ? Pernicious anæmia.
Mary	4.	Tonsilitis.

Acute Rheumatism.

Stephen	10, 30, 35.
Mary	47, 48.

A Fatal Case of Acute Pemphigus, with Notes of Three other Fatal Cases.

1. Ethel M., æt. 8, was admitted under Dr. Pye-Smith on July 4th, for a copious skin eruption accompanied by intense itching.

Previous history.—Two years ago, and twice subsequently, patient is said to have had a skin disease similar to the present one, only very much milder.

Present illness.—A week before admission patient did not feel well, and complained of headache. Two days later a rash appeared on the chest, with patches distributed over the abdomen and limbs. The next day blisters appeared, which burst and discharged a clear fluid, after which, in many places, scabs of dried serum formed. Three days later, patient was brought to the Hospital and admitted.

Condition on admission, July 4th.—Large raw patches were observed from which the superficial cuticle had been removed, and which were discharging a thin serum. Over the front of the chest, abdomen and back, these patches were large and confluent, only leaving a few islets of healthy skin here and there. The appearance of the chest and abdomen, with the extensive raw surface, weeping discharge and dried crusts of serum might, to a superficial observer, have very well suggested an acute eczema. On examining the limbs, however, an earlier stage of the eruption was seen revealing its true nature. On the upper part of the limbs and head the patches were more discrete and smaller, and over the legs, forearms and face, were numerous discrete bullæ, all of which had burst and were more or less collapsed, varying in size from a shilling to half-a-crown. The scalp and palms were slightly affected, but the soles were free. In between the patches the skin was quite normal. There were no bullæ in the mouth or on the conjunctivæ. She was treated with the Ung. Zinci Oleati, full diet, and Chloral and Bromide. In spite of this she was very restless and incessantly scratching, so that I.M.H. gr. $\frac{1}{12}$ had to be given in the evening, after which she got some sleep.

5th. Very restless and miserable. I.M.H. gr. $\frac{1}{8}$ given at 11 a.m. The odour from the eruption was so offensive that the ointment was changed to equal parts of the Ung. Zinci Oleati and Vaselinum Acidi Borici. Dr. Pye-Smith saw her this afternoon and ordered her a warm bath every evening. This soothed her for some time. Chloral and Bromide were given during the night.

6th. She has been taking nourishment very well all along, but is exceedingly restless.

℞ Tr. Opii ... ... ɱij.ss.
Spt. Ætheris Co. ... ɱv.
Syrupi ... ... ʒss.
Aquæ ... ... ad ʒss.
4tis horis sumendam.

The evening temperature was 101·8, and remained raised till the end.

8th. Condition the same, only exhausted with the intense itching, serous discharge and insomnia. She has had a little sleep by snatches and takes abundant nourishment if pressed. Respiration became difficult and laboured to-day, so ℞ Vini Ipecacuanhæ ɱiij. Mist. Ammoniæ ʒss. 4tis horis was substituted for the opium mixture. She had now passed into a condition of mild, asthenic delirium, and brandy ʒi.ss. per diem was being given, though the pulse remained fair to the last.

9th. Liq. Strychninæ Hydrochlor. ɱij.ss. were given subcutaneously at 1.30 a.m. and again at 2.30 a.m., but she died from gradual exhaustion at 5.15 a.m. There was never any albuminuria.

Autopsy.—The condition of the skin was much as described on admission, only the disease was more extensive; in fact, almost universal over the trunk. With the exception of a few patches of collapse at the back of both lungs, nothing else abnormal was found.

The three following fatal cases I have extracted from the post-mortem records during the last 20 years.

2. [1878. P.M. 103]. *Pemphigus—Erysipelas—Chronic Glossitis—Ulceration of Stomach.*

George H. W., æt. 49. Admitted under Mr. Durham, February 26th, for Pemphigus. Four years previously was in the London Hospital, under Mr. Hutchinson, for the same disease, and subsequently an out-patient under Mr. Morrant Baker at St. Bartholomew's. Was much relieved by treatment. For sixteen months previous to admission he had not attended anywhere for treatment. On admission, he was covered with large bullæ. The evening temperature varied between 103·6 and 102·2. On March 9th an erysipelatous rash appeared on the thighs and he died a week later in much the same condition.

Autopsy.—The entire trunk was covered by a number of large superficial excoriations, leaving a raw surface, so that the body was not unlike one of extensive superficial burn. In the few parts not affected (hands, feet, and shins) the skin was rough and marked like a case of Ichthyosis. There were two ulcers on the dorsum of the tongue (*vide* Museum, No. 3486). The lungs showed hypostatic pneumonia on both sides, and there were a number of small superficial ulcers in the stomach. Other viscera healthy.

3. [1882. P.M. 331].—*Pemphigus—Double Pleurisy—Pulpy Spleen—Cystic and Granular Kidneys—Osteo-arthritis.*

Mary A. G., æt. 72. Admitted under Dr. Pye-Smith, October 27th. Had had rheumatic pains at times, and three years previously a carbuncle on the neck. Two months before admission she noticed red patches on the calves of the legs. They got better, but fresh patches, which turned to blisters, came out on her arms, and eventually on the legs, buttocks, scapular region, and right foot, the hands being quite free. She was treated with arsenic and stimulants, but gradually sank, and died on November 4th. The temperature was at times as high as 102, the pulse 130–140, and respirations 60.

Autopsy.—The body was covered with large superficial scabs. The arms and legs had suffered the most, but

the trunk about the shoulder blades was also extensively affected. The skin elsewhere seemed perfectly sound. There was recent pleurisy with collapse at the bases of both lungs. The heart weighed 11½ ounces, and the mitral valve was a little thickened. Liver 58 ounces, healthy. Spleen 24 ounces, extremely pulpy. The kidneys weighed 10 ounces and showed both cystic and granular changes, but there was a fair amount of cortex left and no notable thickening of vessels anywhere.

4. [1888. P.M. 8.]

Charles P., æt. 50, was admitted into Samaritan, under Mr. Golding-Bird, January 3rd. He had had a poisoned finger three months previous, and a poisoned thumb two months previous to admission, both of which got well. Whilst the latter was healing, blisters appeared on the arms, legs and thighs, which, however, got well in three weeks. On December 27th a fresh crop of blisters appeared on the perineum, genitals and thighs, and spread over the buttocks. The genitals became covered with scales, he had incontinence of urine, and temperature 100. Subsequently he became delirious, bullæ appeared on the feet and arms. Temperature 99—99·8. He became more feeble and tremulous, and died of asthenia on January 10th.

Autopsy.—The post-mortem condition is thus described by Dr. Pitt:—There was an extensive area over the gluteal regions, thighs and loins, where there was superficial ulceration, measuring 16 by 22 inches on the right, and 16 by 16 inches on the left side, denuded of epithelium and covered by healthy granulations. This area was thickly dotted over with tiny fragments of skin, looking as if skin-grafting had been performed, but really due to persistence of small areas of healthy skin between the original vesicles and bullæ. At all points of pressure raw surfaces had formed, *e.g.*, over the shoulders, scapulæ, elbows and calves, resembling an extensive scald. On the arms, forearms, hands and thighs, were numerous loose blebs of which the epithelium was sodden and friable. On the ankles, legs, forearms and hands, were numerous ecchymoses of blood-stained serum. The lungs showed some emphysema and œdema. The intestines were congested. Spleen 2½ ounces, not soft. Kidneys 13½ ounces, large, but healthy.

The microscopic appearances are thus described by Dr. Pitt. A section through one of the persistent islets of skin showed intense cell-infiltration of the superficial part of the corium, especially along the blood-vessels and lymphatics. The vessels were engorged with blood and there were small hæmorrhages. The cells of the sweat-glands showed signs of proliferation. In the ulcerated portions the actual loss of tissue varied much. In some places only the horny layer had gone, in others only the deeper epithelial processes persisted, and in others the papillæ were destroyed. The surface consisted of granulation tissue with formation of embryonic new vessels. In some places where the Malpighian layer was still present it showed spaces between the cells.

A. J. S.

CASE UNDER DR. GOODHART.

MARY.

21. A. J., æt. 12. Admitted for vomiting, pain and swelling in abdomen. Patient had rheumatic fever four years ago and has never been well since. About December, 1893, patient noticed her abdomen becoming swollen, and it went on increasing in size till July last, since when it has diminished somewhat; she had pain at times during day which disappeared towards night, the onset of pain being sometimes accompanied by vomiting.

Patient was admitted under Dr. Horrocks on October 11th for abdominal tumour, which, however, could not be felt per rectum. Dr. Horrocks diagnosed ascites, due either to heart trouble or tubercular peritonitis. Patient was transferred to Mary on October 22nd.

On admission.—Abdomen was somewhat distended but freely moveable, and fluctuation but no thrill was obtainable, a firm hard tumour could be felt in epigastrium extending downwards and inwards nearly to umbilicus, with a convex edge; on percussion, abdomen was hyper-resonant all over the front except above the tumour, where resonance was present but not so marked; the flanks were dull, but became resonant when patient lay on one side, to a certain extent; no rub audible over tumour; superficial veins not distended over abdomen; splenic dulness a good deal increased. Area of cardiac dulness lies between third and fourth ribs, a line just internal to nipple and left side of sternum, impulse being in third left space, one inch internal to nipple line (in report from Dorcas it is said to have been in fifth space). A loud systolic murmur is audible at apex, and second sound is accentuated and reduplicated over pulmonary area; there is visible pulsation in carotids; superficial thoracic veins are much distended.

26th. Cardiac impulse distinctly felt in both second and third left spaces; dulness has moved up a little; bruit is audible over much larger area; second sound rather accentuated in second right space, and most distinctly in first left space. Abdomen about same; resonance over tumour less marked. There is some impaired resonance, deficient entry of air and diminished voice-sounds at both bases, especially right.

30th. Abdomen slightly less distended, hyper-resonant at inner portions of hypochondriac regions and upwards under left ribs as high as fifth; resonance in umbilical region and flanks diminished, and dulness over tumour. Systolic bruit audible over nearly whole of front of chest; there is a questionable mid-diastolic at apex. Blood tested found to contain diminished number, about 4,000,000 of red corpuscles, and only 40 per cent. hæmoglobin; no increase in white corpuscles.

Dr. Goodhart saw patient on 29th, and thought case was not one of tubercular peritonitis, as he had never seen so large a mass in such a position, epigastrium. He suggested the possibility of growth, perhaps in the supra-renals, but thought probably it was a case of enlarged spleen with slight ascites. She is taking—

Tinct. Ferri Perchlor.	...	ɱxx.
Mist. Ammon. Acet.	...	ad ʒj. t.d.s

CASES OF DIPHTHERIA TREATED WITH ANTITOXINE.

It seems only reasonable that the following cases should be published and considered side by side with those recently published, in which benefit seemed to follow the injection of Antitoxine.

CASE I.—J. N., æt. 20. Admitted to Mary, under Dr. Pye-Smith, July 6th, with enterica. The case was not a severe one, and progressed favourably till the end of the second week. The bowels acted on an average four times per diem, and the maximum temperature was always under 104. Patient slept and took her nourishment well. On the evening of the thirteenth day she first complained of slight sore throat, and the temperature was 104. On the sixteenth day (July 16th) a thick white pellicle was visible on the soft palate and fauces. An alkaline spray containing morphia relieved the pain. On the seventeenth day the membrane was thicker, tougher, and firmly adherent. On the eighteenth day a fragment of membrane examined by Dr. Washbourn was found to be full of Klebs-Löffler bacilli. An antiseptic spray of iodine and carbolic acid was substituted for the other, and ɱxv. of the Schering-Aaronson antitoxine given hypodermically at noon. This evening the temperature was the highest yet, 104·2. The pulse was weaker and more frequent. The extremities began to get cold and the lips bluish, so the amount of toxæmia was clearly very great. On the nineteenth day the membrane was double its previous thickness. Stimulants were freely given. Another injection of ɱxv. of antitoxine was given at 11.30 a.m., and a third at 7.45 p.m. Two inhalations of oxygen were also given. By this time patient was livid, cold, pulseless, and covered with a clammy sweat. Strychnine was also given, but she died from sudden syncope at 6 a.m. on the twentieth day. Tracheotomy was never considered advisable in this case, and no autopsy was allowed.

CASE II.—Annie W., æt. 8. Admitted under Dr. Pye-Smith, at 2 a.m., September 30th, with severe laryngeal dyspnœa. She was said to have been ill a week. Tracheotomy was done at once, and a large piece of tough membrane removed from the upper part of the opening made in the trachea. Strychnine, iron and brandy were given internally, and a spray of Hydrarg. Perchlor. (1 in 10,000) to the fauces. At 2 p.m. ɱxvij. of Schering-Aaronson antitoxine was given hypodermically, and again at 9 a.m. on October 1st. This exhausted the supply. Patient's constitutional condition was very bad on admission, but improved much the next twenty-four hours after the operation. Respiration, which was at first greatly relieved, again became worse and worse, and she died at 5 a.m., October 2nd, from syncope. The inspection showed the membrane to have invaded the larger bronchi, and there was a great deal on the posterior surface of the soft palate.

Both the preceding cases were undoubtedly severe as regards toxæmia, and it might fairly be urged that not enough antitoxine was given, and that not early enough to be of much service. No appreciable result was observed to follow its use in either case.

DIPHTHERIA—TRACHEOTOMY—ANTITOXINE INJECTIONS—DEATH FROM TOXÆMIA.

E. S., æt. 8 months. Admitted into Clinical, under Dr. Perry, at 11 p.m. on September 22nd, for laryngeal obstruction. Diphtheritic membrane was seen on the fauces. The child's illness, according to the mother's account, dated from the previous day only.

Tracheotomy was performed at 12 noon on the 22nd; patient's dyspnœa was considerably relieved.

On September 24th, at 4.45 p.m., *i.e.*, forty hours after tracheotomy was performed, ɱxv. antitoxine was subcutaneously injected between the shoulders. A second injection of ɱxv. was given at 6.30 p.m. Another injection of ɱx. at 11.15 a.m. on the 25th, and a fourth of ɱxv. at 11. p.m. the next day, the 26th.

The child died at 7 p.m. on the 26th, quite quietly, with no dyspnœa. She was very restless the whole time till just before death. Every now and then slight symptoms of dyspnœa and a little lividity were present, Oxygen inhalations were administered for a few minutes, and gave a good deal of relief.

It is doubtful whether the antitoxine did much in this case; however, it certainly appeared to prolong the child's life. It seemed certain, before the first injection was given, that the child would not live many hours; as a matter of fact, it was fifty hours before the patient died.

Post-mortem. — No membrane below tracheotomy wound. Cause of death, toxæmia.

L. A. P.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ACCIDENT	9.	Hæmatoma of scalp. Concussion.
	10.	Impacted fracture of neck of femur.
	23.	Fractured ribs. Emphysema. Hæmoptysis. Injury to spine.
CHARITY	Cot.	Abscess over mastoid process.
	9.	Fractured femur.
	10.	Popliteal abscess.
	23.	? Pelvic peritonitis.
NAAMAN	3.	Swelling about shoulder-joint. Necrosis of neck of scapula.
	4.	Malignant stricture of œsophagus.
	6.	Serous synovitis of ankle. ? Syphilis.
	17.	Enlargement of thyroid. Removal.
	19.	Inguinal bubonocele. Varicocele.

CASES UNDER MR. DAVIES-COLLEY.

LUKE	9.	Popliteal aneurysm.
	11.	Carcinoma of rectum.
	18.	Dysphagia. ? Malignant stricture of œsophagus.
LYDIA	7.	Acute arthritis, ankle-joint, lupus, etc.
	8.	Cleft palate. Operation.
	19.	Congenital talipes equino-varus.
	21.	Scirrhus mammæ.

CASES UNDER MR. LUCAS.

CHARITY	4.	Carcinoma recti.
	23.	Multiple adenomata, both breasts.
JOB	3.	Locomotor ataxy. Suppurating corn on under surface great toe.
	17.	Sacro-iliac disease.
	24.	Retained testicle.
LYDIA	13.	Contracted fingers, following burn.

CASES UNDER MR. GOLDING-BIRD.

LAZARUS	5.	Fibrous epulis.
	7.	Spinal caries. Psoas abscess.
	10.	Hæmaturia. Obstruction to defæcation. Bladder or prostate growth.
	13.	Stricture. Suppurative epididymitis. ? Tubercular.
	15.	Stricture. Cystitis.
	22.	Periostitis of femur.
MARTHA	—.	Varicose veins.
	3.	Ovarian cyst.
	9.	Fracture of upper dorsal spine. Complete paraplegia and loss of sensation below line of fracture.
	13.	Pus in antrum.
	20.	Eversion of foot. ? Displacement of astragalus.

CASES UNDER MR. LANE.

JOB	13.	Mastoid abscess. Antrectomy.
	14.	Appendicitis.
	20.	Cystic swelling in thigh in connection with knee-joint.

With Dr. Perry in the Skin Department.

SOME UNCOMMON CASES.

Lupus verrucosus.—An old lady came up complaining of a patch of skin disease on the left wrist. It originated from a slight injury received five months previously. It was about three inches long by one inch broad, the edges sharply defined, and there were no outlying patches; the surface was raised and distinctly warty. The diagnosis rested between epithelioma, eczema verrucosum, Laloir's disease (pustular folliculitis), syphilis, and lupus verrucosus. Against epithelioma was the absence of induration and the very small amount of ulceration; against eczema verrucosum was the duration, only five months, and the fact that there was only one strictly limited patch and no eczema anywhere else; against Laloir's disease was the absence of pus exuding from the hair follicles; there was no evidence of syphilis, and therefore the diagnosis of lupus verrucosus was made; iodoform ointment was ordered, the question of scraping being reserved for future consideration.

Telangiectasis.—A man, æt. 38, attended for a slightly raised dark-red tumour occupying the whole of his left cheek; it looked exactly like a nævus of the cheek, but he is quite sure it was not a birth-mark. He dated it from an injury received there fifteen years previously. There was also a small spider nævus on the nose. Diagnosis, telangiectasis. This differs from a nævus in not being congenital; it is an enlargement of vessels previously existing rather than a formation of new ones; the present example was peculiar, owing to its large size. Treatment: either leave alone as it was not a very unsightly thing; or treat surgically.

Pityriasis rosea.—T. E., a boy, 10 years old, presented himself with numerous pale red circular patches over the front of chest, back and abdomen, and a few on the arms; they varied from about one-sixth to half an inch in diameter, were slightly raised above the surface, and covered with a small number of scales; the diagnosis rested between psoriasis, tinea circinata, lichen circumscriptus, squamous syphilide and pityriasis rosea. Psoriasis: the patches did not occur in the typical situations for this disease, they were too little raised and not sufficiently scaly; tinea circinata: too numerous and too rapidly developed, and the patches were not circles made up of papules with a clear centre; lichen circumscriptus: never occurs on limbs, and the border was not papular and elementary lesions not papules; syphilide: age of patient against this, no other symptoms or evidence of syphilis. Diagnosis: pityriasis rosea. Treatment: unguentum oleatorum. L. A. P.

Three Cases of Diphtheria treated with Antitoxin.

1ST CASE.—L. H., æt. 2½ years. No previous illness except varicella. Last in contact with cases of diphtheria on August 18th. On that day she was isolated at a house a mile away; her throat was examined twice daily after that date. On the 21st she was put on Liq. Hydrarg. Perchlor. ʒss. t.d.s. Fauces rather red. On the 24th, at 4.30 p.m., there was a small patch of membrane on the left tonsil. It looked like a little speck of condensed milk, about one-twelfth of an inch in its long diameter, which was from above down, and exactly resembled the first appearance in the other two children with whom she had previously been in contact, and as in their cases, it arose on the left tonsil. Temperature 98·6; no glands nor stiff neck; apparently in usual health, except slightly pale. At 11 p.m. patch distinctly larger, and heaped up in the middle. I gave her chloroform, and Mr. R. W. Murray cauterized the patch, and about a quarter round with the benzoline cautery. The anterior pillar was accidentally touched at the same time.

25th. Had spent rather restless night owing to chloroform vomiting. Temperature 98·4. Anterior pillar where burnt showed white filmy patch contrasting

with seat of diphtheritic patch, which was about a quarter of an inch in diameter and yellow in colour. In the evening the patch covered anterior half of tonsil; rest of fauces clear. Temperature normal; no glands nor albumin. Child pale, appetite bad; out all the day in the garden. In fact, throughout her illness she spent most of the day there. The Liq. Hyd. Perchlor. ʒss. was pushed to 3tis horis.

26th, 4 p.m. Antitoxin ɱx. (Aaronson's) injected into buttock. Liq. Hyd. Perchlor. stopped. At 11.30 a.m. the membrane, which had not been looked at since 5.30 p.m. on previous day, covered nearly whole of left tonsil, but the posterior margin appeared to be loose. Child lively and taking food well. At 3 p.m. membrane all gone except a piece which had formed anterior margin of patch. Membrane probably came off during dinner, as she then complained of a hair in her throat.

27th. Membrane growing again. At 3 p.m., about thirty hours after injection of antitoxin, membrane was scraped off for bacteriological examination, but most of it was swallowed. A small piece was saved, from which four cultivations were made at Guy's, but no Klebs-Löffler bacilli found. At 5.30 p.m. all the antitoxin left, ɱvij., was injected.

28th. No fresh membrane; the last traces were scraped off in a deliquescent condition, and mixed with saliva, were sent to Guy's, and Klebs-Löffler bacilli were found. These examinations were simply confirmatory, as the case was considered typical, as were those which preceded her's, for whom no antitoxin was obtainable. Of them, her uncle had post-diphtheritic paralysis, her aunt a considerable amount of membrane, a female cousin aged four years died on the sixth day of her illness, whilst tracheotomy was being performed; fauces all covered with membrane and œdematous, and membrane on lower lip, owing to bite. Temperature 101, and albumin one-third. The male cousin, aged six, had membrane all over fauces, which had cleared away on seventh day. On eighth day, relapse with fresh membrane and œdema of left tonsil and uvula, which afterwards became permanently adherent. As to my little girl, as a fresh lot of antitoxin (Roux) arrived on the 28th, ɱxv. were injected, and she made an uninterrupted recovery, except that from September 1st to 3rd round the sites of injection developed erythematous patches the size of half-crowns, which remained for some days, and appeared to be tender.

2ND CASE.—F. G., æt. 29, clerk at soap works. Delicate throat. Tour on Continent. Left Brussels September 11th. Had been staying at Hôtel de Vienne. Said that smell of w.c. there was abominable. Joined his wife and children at Southport on September 12th.

14th. Shivering herpes on upper lip in evening, otherwise felt well.

15th. Woke up with sore throat, which rapidly got worse during day. Returned home to Newferry in afternoon, and was seen by my locum. No headache, great lassitude, no glands nor stiffness of neck; no back ache, but aching in knees. Temperature 103·2. Membrane on both tonsils. Liq. Ferri Perchlor. and Pot. Perchlor. internally and Boracic Acid spray locally.

16th. Much worse; tonsils and uvula covered with membrane; felt very ill all day, especially towards night. Temperature 103·6. Owing to earnest solicitations of my wife, the locum that evening injected ɱxx. antitoxin (Roux).

17th. Rather better in the morning. Felt better still in the evening. Membrane coming off. Temperature normal and subnormal during day. Antitoxin ɱxx. repeated in evening.

18th. Feels almost well; membrane nearly all gone.

19th. Quite lively; last speck of membrane seen that evening, when I returned, but I had not, unfortunately, anything to put it in. Uninterrupted convalescence.

3RD CASE.—A. G., æt. 2, son of above. Was at Southport with mother and baby brother, æt. two months. Father joined them on 12th. Returned to Newferry on 15th.

17th. Had stiff neck; no appetite, fretful.

18th. Owing to wire from me, the locum injected antitoxin ɱxv., and did the same to mother and baby. On this day the throat was not examined.

19th. On my return in the evening there was a soft-looking patch of membrane on the soft palate between the left tonsil and uvula. The neck was tender, and there was one enlarged gland on left side. Temperature 99·4. Pulse 138. Antitoxin ɱxv. given.

20th. Temperature 97·2. Membrane gone. Convalescence uninterrupted. The boy took about a week to recover his appetite; no erythema round sites of injection.

The antitoxin used in the last two cases was received from Dr. Roux on August 28th. It had when used a small cloud of mould in it, but as no other could be obtained in time, it was used.

FRANCIS HEATHERLEY.

Newferry, October, 1894.

A Nervous Case for Commentary.

UNDER DR. GOODHART.

A. H., æt. 37, was transferred to Philip, under Dr. Goodhart, on August 22nd, having been in John a fortnight, where he was admitted for difficulty in walking.

Father died of phthisis; no other fact of importance in family history. Entered Army in 1876, being stationed in Gibraltar and Ireland, and bought himself out in 1880. Since 1881 has worked in hot drying-room in ammunition factory: labour not very hard. In 1878 had suppurating buboes in groin; no urethral discharge. No history of syphilis or injury to back.

Patient's legs became weak in end of 1893, accompanied by general languor. In April, 1894, giddiness and difficulty in walking came on; gave up work in May, and in July his right arm became weak.

In *Clinical*, his mental power is noticed as normal; reels on walking and cannot turn quickly; sways when he shuts his eyes, and cannot walk well in the dark; slight inco-ordination in right arm; grasp of right hand 55 pounds, and in left 105; corresponding difference in legs; no contractions or tremors; drags his feet when walking; no sensory changes except occipital headache for last month; knee-jerks exaggerated, especially right; depressed patellar reflexes present, right more active; ankle clonus marked on right, less so on left; elbow-jerks marked; slight wrist-jerks; slight rectus clonus. Pupils equal, react normally but sluggishly; vision good; discs normal; nystagmus on movement in any direction. Hearing, speech, smell and taste normal. Considerable wasting of muscles of limbs. No bladder or rectum symptoms. *Urine* normal except for alkaline reaction.

Patient's tongue is furred and yellow; was sick once a month during illness; vomit yellow; latterly vomiting has been more frequent.

℞ Sod. Sulpho. Carb. ... gr. x.
Sp. Ammon. Aromat. ... ʒss.
Inf. Gent. Co. ... ... ʒi. t.d.s.

August 13th. Right ankle clonus gone; knee-jerk less; muscles tested and found normal.

In *Philip.*—Besides above, his speech is noticed as slow and deliberate; is deaf on right side, which defect has existed for years; hearing of left ear also impaired. Arteries are tortuous and atheromatous. Respirations slow (ten per minute).

28th. Headache, not localized, for one day. Tonics given.

September 3rd. Knee-jerks both diminished; no plantar reflex, ankle clonus, elbow or wrist-jerks.

8th. Headache, and sick once. On walking he drags his right leg; gait not ataxic; rather giddy in character.

11th. Right eye normal; left disc obscured on inner side. During the latter part of the month headache and sickness are frequently noted. Mist. Methylacet. ʒj. s.o.s.

Pot. Iod.... ... ... gr. x.
Mist. Hydr. Perchlor. ... ad ʒj. t.d.s.

October 1st. Speech worse, halting and irregular: knee-jerks bear the same reactions; no signs of syphilis anywhere. He has now lost control of bladder and rectum.

Pot. Iod.... ... ... gr. x.
Liq. Hydr. Perchlor ... ♏ 80.
Mist. Sod. Sulph. ... ad ʒj.

6th. Right knee-jerk normal, left absent. No vomiting; headache almost constant, in region of coronal suture; lack of energy general. The left disc is flattened and red; edges are dim; at the centre is a small white spot. Edge of right disc wavy and indistinct; colour normal. No optic neuritis or atrophy.

9th. Relative power of limbs of two sides unaltered. No alteration of special senses, or paralysis of muscles of eye, tongue, palate or larynx. He was made to walk again to-day, when the previous condition was even more marked. Abdomen is much retracted, and he is very thin. He is subject to hot flushes on observation and after being washed.

16th. Now right knee-jerk has gone; mental condition worse, and speech very slow. Loss of control of sphincters is complete. Respiration 5—10 per minute. No anæsthesia; cutaneous reflexes normal, *e.g.*, cremasteric. Right disc is in condition of left on 6th, while the left is paler; edge only known by pigmented rim; veins full, arteries small and rather tortuous: sight worse with left eye. Was carried away by friends this morning almost helpless.

Pass List.

University of Durham, September, 1894.

EXAMINATION FOR THE DEGREE OF DOCTOR OF MEDICINE FOR PRACTITIONERS OF 15 YEARS' STANDING.

D. Elcum, M.R.C.S., L.S.A.
A. Kinsey-Morgan, M.R.C.S., L.S.A.

EXAMINATION FOR THE DEGREE OF DOCTOR OF MEDICINE.

Carr, T. Blachford, J. V.

Final Conjoint Examination, October, 1894.

MEDICINE, SURGERY, AND MIDWIFERY.

*Copley, S. *Eastes, G. L.
*Robinson, W. E.

MEDICINE AND MIDWIFERY.

*Armer, A. Salter, A.
Fry, A. C. Van Someren, E. H.

SURGERY AND MIDWIFERY.

*Hopkins, F. G. Horton, J. H.
Wilkins, J. C. V.

MEDICINE ONLY.

*Bond, C. S. *Moon, R. H.
*Brereton, F. S. *O'Leary, E. G. E.
*Burroughs, W. J. *Packer, H. D.
*Evison, F. A. *Reynolds, B. G.

SURGERY ONLY.

*Allport, A. Loud, F.
Culmer, J. J. Peake, W. H.
*Colley, C. R. Pern, H.
*Drake, E. H. *Peters, E. A.
Serjeant, R.

MIDWIFERY ONLY.

*Barr, V. H. Lane, J. G. O. H.
Byford, W. F. *Matthews, A. K.
Ensor, C. A. Smith, H. J. Milbank.
Kearney, C. J. Van Leent, H. J.

* Denotes completion of examination.

Passim.

THE Debating Society meets to-night in the Club Smoking Room, at 7.30. Mr. Fripp will preside. Mr. Hamblin Smith will propose "That this House emphatically condemns the action of the Licensing Committee of the London County Council with regard to the Music Halls." Mr. E. L. Spriggs will lead the opposition.

THE following meetings are announced to take place shortly :—The Physical Society meets on Saturday next, November 10th, at 8 p.m., when Mr. L. A. Parry will read a Paper on the "Treatment of some Diseases by Thyroid Extract." The Dental Society meets on Tuesday, November 13th, at 4.30 p.m., when Mr. H. Wallis will read a Paper on "Electricity in the Service of Dentistry." The Christian Union meets on the 8th instant, to hear an address from Mr. H. A. Flowers, and on the 15th three of the members will give short addresses.

WE have been requested to announce that for the future two Examinations will be held during the year for the degree of M.B., B.Ch. of the University of Oxford, in both the Intermediate and Final Examinations.

WE have of late been extremely pressed for space, and must again crave the indulgence of our disappointed contributors; most, if not all, of the matter unavoidably excluded from the present issue will be inserted in our next. *Inter alia*, we have to acknowledge several articles on "Specialism and the Science of Medicine;" "Cremation Compulsory," "Some cases treated with Sulphur," a "Case of Snake Poisoning," and some interesting Correspondence.

WHILE we are writing of "Contributions," may we be allowed to remind our contributors to write upon ONE side of the paper only.

WE offer our congratulations to Mr. W. C. C. Pakes on his appointment as Assistant Demonstrator of Bacteriology. He has already done good work in the laboratory, as a study of his excellent paper, the concluding portion of which we publish to-day, shows.

MR. A. L. Roper is also to be congratulated on his appointment as Clinical Assistant in the Throat Department.

WE regret to announce the death of Mr. Thomas Stiles, L.S.A., M.R.C.S., which occurred on the 27th instant, at Spalding. The deceased gentleman, who was until his death the oldest Guy's man in existence, had reached the ripe age of 96. We hope to be able to give some interesting details of his career in our next, and we shall be glad to receive reminiscences of his life from any old Guy's men who knew him.

Books recently added to the Hospital Library.

Herman's First Lines in Midwifery.
Herman's Difficult Labour.
Hewitt's Anæsthetics and their Administration.
Hill's Physiologist's Note-Book.
Quain's Dictionary of Medicine, 1894.
Tomes' Dental Anatomy, 1894
Gamgee's Physiological Chemistry, vol. ii.
Ross and Bury's Peripheral Neuritis.
Ottenlinqui's Practical Dentistry.
McEwen's Infectious Diseases of the Brain and Spinal Cord.

PRESENTATIONS.

Dr. Galabin's Manual of Midwifery, 1894. By the Author.
Dr. Pavy's Physiology of the Carbo-hydrates. By the Author.
Dr. Mercier's The Lunacy Laws for Medical Men. By the Author.
Professor Osler's On Chorea. By the Author.
Dr. Seymour Taylor's Index of Medicine. By the Author.
Transactions of the Provincial Medical and Surgical Association. Dr. E. *Elliott*.
Thesis :—
"On the Relationship between 'Idiopathic' Pleurisy with Effusion and Tuberculosis." A Thesis for the Degree of Doctor of Medicine. By E. H. Cartwright, M.D., B.Ch. Oxon.

Diphtheria.

Paper read before the Physical Society on 13th October, 1894, by Mr. W. C. C. Pakes.

(Concluded.)

I have spoken of the bacillus diphtheriæ, or the Klebs-Löffler bacillus, as being the cause of the disease. In 1883, Klebs first demonstrated the presence in the membrane of diphtheria of a micro-organism peculiar to the disease, and in the following year Löffler succeeded in isolating and cultivating it. At the present time there are the following proofs that it is the cause of the disease.

1st. In all cases of diphtheria which have been examined by competent observers, the bacillus has been found. Löffler, Roux, Yersin, Welch, Abbott, and others, who have all examined a large number of cases which were undoubtedly diphtheria, have been able to demonstrate it in practically every case.

2nd. It is only found in diphtheria. Many observers, including Löffler, Von Hoffman, Neisser, have found a bacillus very similar to, if not identical with, this Klebs-Löffler bacillus, but which was found to be non-pathogenic. I shall speak of this pseudo-diphtheria bacillus later. At the same time there are present, besides putrefactive bacteria, which are practically constant, but external to the membrane and washed off by sterile water, either a form of streptococcus similar to the streptococcus erysipelatosus, or a staphylococcus pyogenes (albus or aureus), or both. Welch and Abbott say that the only organism which they have found constant has been the Klebs-Löffler bacillus. Other observers, however, have found one of these cocci always present. In the membranes which form on the throats of patients suffering from scarlet fever or measles, either one or other of these cocci is constant, but the Klebs-Löffler bacillus never present, except in those cases previously mentioned, and proportionately few, where the two diseases run a simultaneous course. In measles the same is also true.

3rd. Pure cultures of this bacillus, when inoculated into some of the lower animals, have produced membranous exudations. The rabbit, for instance, has been inoculated by Roux and Yersin in the trachea, and has shown the same clinical symptoms as man, viz., dyspnœa, stridor, etc.; at the post-mortem examination, the mucous membrane of the trachea was found swollen, œdematous, and covered with a false membrane, and the glands of the neck were infiltrated and enlarged. The membrane, however, in the rabbit is not well marked nor easy to produce; many die of sapræmia when inoculated in this manner, without showing any signs except inflammation at the seat of inoculation. Welch and Abbott inoculated a kitten, and gives this account: "A half-grown kitten was inoculated into the trachea with one platinum loop of a pure cultivation of Löffler bacillus on glycerin-agar eleven days old. For the inoculation a small median incision was made ove the trachea, in which a hole just large enough to admit the platinum loop was made. The culture was rubbed over the mucosa of the trachea for an extent about three centimetres in length, and in this process sufficient force was used to abrade the mucous membrane. On the day following the inoculation no special alteration in the animal was observed, but on the second day it was found very weak. In the course of this day it became so weak as to lie completely motionless, apparently unconscious, with very feeble shallow respirations. Several times it was thought to be dead, but on careful examination proved still to be breathing feebly. It was found dead on the morning of the third day. At the autopsy the wound was found gaping, and covered with a greyish, adherent, necrotic, distinctly diphtheritic layer. For a considerable distance around the wound the subcutaneous tissues were very œdematous, the œdema extending from the lower jaw down over the sternum, to the side of the neck and along the anterior extremities. The lymphatic glands at the angle of the jaw were markedly swollen and reddened. The mucous membrane of the trachea, beginning at the larynx and extending down for six centimetres, was covered with a tolerably firm greyish-white loosely attached pseudo membrane, in all respects identical with the croupous membranes observed in the same situation in cases of human diphtheria."

4th. The symptoms so common after an attack of diphtheria have been accurately reproduced by the inoculation into animals of the toxins developed in bouillon by the growth of the bacillus, and the nerves have subsequently been found degenerated.

The bacillus diphtheriæ, or, as it is commonly called, the Klebs-Löffler or Löffler bacillus, is a straight or slightly curved rod with rounded ends, from 2 to 3 μ in length, and from 0·5 to 0·8 μ in diameter. Irregular forms are very frequently met with, and especially from cultivations on unfavourable media. In unstained specimens, one or both ends may appear swollen and more highly refractile than the remainder of the bacillus. When stained, the peculiar characteristics of the bacillus may be easily demonstrated. If a specimen be coloured with carbolic methylene blue, and a single typical bacillus examined under a high power, it will have the appearance of two or three round or oval bodies in a short chain; these dots are not, however, of the same size, as would be the case if they were the components of a chain of streptococcus or part of a mass of staphylococcus. One or two of the dots, at one or both ends of the rod, are considerably larger than the others. If the specimen has not been very well washed after staining, it is easy to imagine that there is a capsule round these dots, and if rubin or Bismarck brown be used as a counter-stain, this apparent capsule is stained so that the bacillus appears as a brown rod with differentiated protoplasm stained blue. However different the forms may be in any specimen, this clear differentiation of the protoplasm is always to be observed. In some of the short rods only

one of the blue stained dots may be seen, in others two, three, or four. The specimens grown on potato show as a rule the largest number of dots. If the differentiation is not well marked, and the dots are inclined to run into one another, a number of the bacilli appear distinctly pear-shaped, or rather, Indian-club shaped, or the shape of two Indian clubs joined in line by their necks. The bacillus stains easily with carbolic methylene blue, alkaline methylene blue, or carbolic fuchsin; rather less easily with other of the aniline dyes, and with a little care can be stained by Gram's method, which consists of staining with aniline-gentian-violet, washing with a solution of iodine in water with potassium iodide in solution, and then with alcohol, the bacillus not being decolourised.

Biologically it has these properties: It is ærobic and facultative anærobic, *i.e.*, it grows easily in presence of, but will grow with difficulty in absence of oxygen. It is non-motile, it does not form spores—multiplication taking place by fission only. It does not peptonise albumin or gelatine, and is therefore called non-liquifying. It grows in bouillon, on alkaline gelatine, agar-agar, glycerin-agar, potato, and milk, but the best media upon which to cultivate it is either sterilized blood serum, or a mixture of blood serum, bouillon, peptone, grape sugar and salt in the proportion of three of serum, one of bouillon, with one per cent. each of peptone and sugar, and one half per cent. of salt.

In bouillon generally a diffuse fine cloudy growth takes place, but sometimes whitish masses adhere to the sides or bottom of the test-tube. The reaction becomes at first acid and then alkaline.

Streak cultivations on gelatin, agar, or glycerin-agar produce small greyish colonies, which when magnified about eighty diameters, appear round or oval, coarsely granular, with rather irregular and ill-defined edges.

Stab cultures on the same media produce growth along the line of the stab with the same characteristics as appear in streak cultivations.

On potato, after forty-eight hours, a casual inspection would induce the observer to think that no growth had taken place. On careful examination, however, holding the cultivation to the light so that the irregularities of the surface are easily seen, it will be noticed that about the spot of inoculation the surface of the potato has a glazed appearance. If a sterilized wire be rubbed on this surface, and a cover-slip preparation be made, the bacilli will be seen in large numbers. The colour of the colonies is so identical with that of the surface of the potato that several observers have asserted that the bacillus will not grow on that medium.

In milk the bacillus grows at a low temperature, 20°C., and in fact grows more quickly at a relatively low than at a high temperature. The milk is slightly curdled and the reaction becomes acid.

On blood serum the colonies are greyish white, elevated, and have a moist appearance. On this medium they grow very quickly, so that at the end of twenty-four hours or even less, the colonies are of medium size, at a time when the streptococci and staphylococci from a membrane are yet, as it were, in their infancy.

The organism can be cultivated between 19° C. and 42° C. Outside these limits no growth takes place.

If a growth on any of these media be kept moist, the bacillus retains its vitality for four or five months; when allowed to get dry for a few weeks, both of these periods are shortened if there be abundant light. The bacillus is killed by an exposure of ten minutes to a temperature of 58° C.

A marked change takes place in the virulence of the organism when it has been passed through a large number of subcultures, or when it has been cultivated at about 39° C. in a current of oxygen. The further the remove from the original culture, the less virulent it becomes, until a time arrives when it has lost its virulence entirely, and is, as regards this property, reduced to the level of the pseudo-diphtheria bacillus.

The virulent bacillus is pathogenic for guinea-pigs, cats, less so for rabbits, hardly at all for rats and mice. When 0·1 to 0·5 cc. of a bouillon culture is injected under the skin of a guinea-pig, it dies in from one to five days. At the autopsy, the seat of inoculation is found to be hyperæmic and ecchymosed, with a greyish white fibrino-purulent exudation, containing a large quantity of the bacilli; the peritoneum, pericardium and pleura contain more fluid than normal; the liver, heart and kidney are generally undergoing fatty change; and the supra-renals are enlarged and hæmorrhagic. No bacilli have been discovered in the blood from the arteries or veins, or from any of the organs. Before death, guinea-pigs and rabbits often show paralysis or paresis of the posterior limbs, shallow quickened respirations, and a feeble and quick pulse.

In the mouths, or on the tonsils of healthy people, a bacillus is occasionally found, which is undoubtedly very similar to the bacillus diphtheriæ. Löffler first made the observation, but was unable to find more than isolated cases. Roux, Yersin, and subsequently other observers, including Welch and Abbott, also found it. There is still a considerable amount of conflicting opinion as to the real character of this so-called pseudo-diphtheria bacillus. Löffler and his followers say that there is a morphological difference between the true and the pseudo forms. Others, following Roux and Yersin, contend that it is merely a non-pathogenic variety of the true bacillus diphtheriæ. (I might here digress for a moment, to remind you that the occurrence of non-pathogenic forms of pathogenic micro-organisms is not uncommon. Besides this bacillus, the bacillus anthracis and pneumococcus both lose their pathogenic properties when they are subcultured many times, or grown upon unsuitable media).

Comparing it with the Klebs-Löffler bacillus, the pseudo-diphtheria bacillus has been stated to show the following differences:—

On blood serum the colonies have the same general appearance, but are larger, denser, more moist, and more opaque.

On agar the colonies are larger.

On gelatine they are identical in appearance, but the true will grow as low as 19° C., whereas the pseudo will not grow below 22° C., according to Klein.

On potato it grows with moderate rapidity, and spreads out over the surface; it has a more brownish appearance than the true bacillus.

Under the microscope it presents all the bizarre forms of the true bacillus; but some authorities say that to an experienced eye it is larger and coarser.

By far the greatest, and only really palpable difference, lies in the fact that the pseudo bacillus is not pathogenic for the same animals which are killed by the true prototype.

Weighing up the whole evidence, it seem to me more probable that the pseudo is merely a non-pathogenic variety of the Löffler bacillus. As I have previously reminded you, the true virulent bacillus can be cultivated in the laboratory at a temperature of 39° or 40° in a current of oxygen, and by this means be robbed of its virulence, without interfering with its vitality. If, then, it is possible artificially to produce a non-virulent form, it is not absurd to suppose that the throats of certain healthy people do not form a suitable soil for the normal growth and development, and that the constant current of oxygen in the throat, in a warm, moist atmosphere, may in the process of time convert the virulent into a perfectly harmless organism.

Having found, then, that a form to all practical purposes identical with the true bacillus exists in the throats of people not suffering from diphtheria, how is it possible to say when any individual case is diphtheria? The whole question lies in the number of colonies which grow. All observers agree that in cases of diphtheria the number of colonies of the bacillus diphtheriæ is moderately large, whereas those who have worked with the pseudo form state that the number is small, some times only one or two colonies on the surface of the medium. In those cases which have clinically appeared to be diphtheria, but which have rapidly cleared up without any of the symptoms of the disease, when this pseudo bacillus has been present it has been in very small numbers, whilst the staphylococci and streptococci have been increased.

The membrane itself is white in appearance, is moderately thick, has a tough consistence, and can often be stripped off in large plates. On making a section through a tonsil covered with membrane the membrane itself is seen to have been formed underneath the epithelium. The epithelium is seen to be dead, necrosed, and to have become hyaline; under this is a layer of inflammatory products containing a large number of living cells, red corpuscles, fibrin, etc., which decrease in number as the basement membrane is reached. The basement membrane itself is partially hyaline, as also are the walls of the blood vessels, although they are at the same time permeable to the blood. Micro-organisms are found outside, in, and underneath the epithelium. Externally there are both many and many sorts, but the majority of them are saprophytic, and can be washed off by shaking in water. In the cellular layer the specific bacillus and pyogenic cocci are found, and these decrease in number as the cells decrease on the approach of the basement membrane. No bacilli are ever found in either the blood vessels or lymphatics.

As all observers have agreed to the fact that the bacillus is never found in the blood or organs of human beings or animals experimentally inoculated, it is evident that it cannot be the immediate cause of the heart failure or paresis which accompany the exhibition of the virus. Some other cause must therefore be found to account for the symptoms; but as they are constant though varying in degree, it appears evident that the bacillus must be considered the ultimate cause. Roux and Yersin were the first to try the effect of the injection of the broth without the bacilli into animals, and they "struck oil," so to speak, at once. Having obtained a pure culture in veal broth they filtered it through porcelain in order to eliminate the bacilli; the bacillus-free broth they then injected into rabbits, and found that they died after showing paresis of the hind limbs and respiratory apparatus. The next step was to find the poison; they found that the toxic substance was precipitated by alcohol, and that the precipitate re-dissolved in sterile distilled water, when injected into rabbits produced the same results. From the small amount required, and the length of time it worked in the animal, and from the further fact that boiling destroyed its action, they arrived at the conclusion that the poison was of the nature of a ferment. Their experiments were repeated by Breiger and Fränkel, and confirmed.

More recently, Sidney Martin has been engaged in the investigation of these toxic products. He took the spleen, kidneys, and other organs of an animal which had died after inoculation with diphtheria, finely mixed them and placed them in rectified spirit where they were allowed to remain until all the proteids were coagulated. The whole was then filtered and the residue extracted with cold distilled sterilized water until nothing more would dissolve. This solution he evaporated at 35° C. to a small bulk and threw it into absolute alcohol. He again filtered and dissolved the residue in water; this was repeated several times to insure the absence of anything soluble in alcohol. After allowing the substance thus prepared to stand in alcohol for six weeks, the precipitate was dried in vacuo, and dissolved as required in cold water. The solution gave all the reactions of deutero-albumose with a small quantity of hetero-albumose. The same process was performed with membrane taken from a diphtheritic throat, and also with a broth cultivation made with alkali-albumin instead of peptone as ordinarily, and filtered free from bacilli.

The tissue albumoses were injected into a rabbit. A small dose caused some fever which passed off. A large dose caused paralysis of the hind limbs, coma, and death. Small doses repeated daily for two or three days, so as nearly to imitate the normal absorption in the disease, caused paresis, gradually increasing in extent and severity

with increasingly rapid respirations followed by convalescence and recovery, or death. At the post-mortem the blood was found to clot slowly; the heart showed fatty degeneration, and the nerves showed conclusive evidence of the peripheral neuritis indicated during life by the paresis. He thus describes the appearance of the nerves: "When the nerve is teased with needles from the normal part to the end of the small branches, it is found that at the upper part the fibres are normal; a little lower down they show a breaking-up of the white substance of Schwann, which is becoming thin and is but little stained with Osmic Acid, while lower down the white substance disappears altogether. Beyond this the white substance again appears, but it is very pale, granular, and broken up; lower down still it regains its dark colour. The primitive sheath of the nerve is intact throughout. The axis cylinder may be intact down to the spot at which the white substance disappears altogether, and even through this part, so that here the majority of nerve fibres consist only of axis cylinder and primitive sheath. Below the point at which the white substance has disappeared, the axis cylinder is in many cases broken. After such rupture, the nerve fibre below undergoes Wallerian degeneration."

When a single injection of the substance obtained from the membrane was made, the same result occurred as after a succession of inoculations with those obtained from the tissues, namely, slight pyrexia, increasing paresis, increasing rapidity of respirations, coma and death.

What, therefore, in all probability happens to patients suffering from diphtheria, is this:—The bacillus on the membrane produces a ferment, which acts upon the local tissues, and gives rise to these toxic albumoses, which are absorbed (this must necessarily be small in quantity from the small surface so often implicated, and this small amount could not produce the lesions which occur); in addition to this, however, the ferment is absorbed into the blood, and whilst there, or in organs such as the spleen, still continues its action and forms the albumoses in larger quantities, so large that they are able to produce the fatty degeneration of the heart and peripheral neuritis, or cause death from heart failure. There is one rather strange feature, however, in connection with this explanation. Judging *á priori* one would imagine from the evidence, that the greater the membrane, the greater would be the production of ferment; the larger the amount of toxin produced, the severer the cardiac and paralytic symptoms; this is not the case; the severity of the disease cannot be measured by the amount of membrane.

Having now described the disease and the organism, it remains to show how to diagnose the disease from the presence of the bacillus, or in other words, how to obtain it from a throat. First it is necessary to obtain some of the exudation, and this may be done in two ways: either by rubbing a sterilized platinum wire, or a plug of sterilized cotton wool, over the abraded mucous membrane; or by detaching a portion of the membrane with a pair of fine alligator forceps, long sinus forceps, or in the absence of these, with a pair of ordinary dressing forceps. Whenever possible the latter method is the better. The detached piece of membrane is then placed in a sterilized test-tube if it has to be carried, or into a test-tube of sterilized water if the inoculation can be done on the spot. It is well shaken up and transferred to a second, and if the odour from the throat is very fœtid, a third may be used with advantage. As you are aware, the saprophytic organisms are confined to the exterior of the membrane, and therefore washed off by this method. The membrane is then picked up on a hook of platinum wire, carefully lowered into a blood-serum tube, and then dragged up over the surface of the serum; or, the water having been poured off the membrane, a straight platinum wire may be well rubbed on it, and the serum inoculated from the wire. The tube is now labelled and placed in the incubator, whose temperature is regulated at 37°C. In eighteen hours the tube is ready for examination. Upon inspecting it several greyish-white colonies of moderate size will be seen, surrounded by a large number of very minute translucent colonies. The larger ones will be the colonies of the bacillus diphtheriæ, and will be recognised as such under the microscope after having been stained. If the membrane is not well washed before the serum is inoculated, there will be at the end of eighteen hours a number of colonies, not at all unlike those of diphtheria, and which, when examined under the microscope, resemble that bacillus rather closely, especially if examined under the "sixth." I might say that although Sims Woodhead states that anyone with a little common sense and a slight knowledge of the Klebs-Löffler bacillus can diagnose the disease for himself, when I first started working with diphtheria, this organism got into my cultures and I wasted three weeks on him.

When these methods are used for the diagnosis, instead of relying on the clinical appearances, by any one who has had a little experience and who will use every care, I venture to say that not one case in a hundred need fail to be recognised, and what is perhaps as important, no greater proportion of non-diphtheritic throats need be called diphtheritic.

Lastly, the treatment of the disease.

As the disease is primarily local, and as we know the cause, it would seem rational to endeavour to check the growth of the bacillus at the seat of inoculation —the throat. With this end in view, physicians have tried various remedies, and many claim more or less success with their own pet panacea. Among the local applications might be mentioned painting the throat with nitric acid, or paraffin, spraying it with carbolic acid (1 in 40 or 60), hyd. perchlor. (1 in 2000), thymol, sulphurous acid, pot. chlor., boracic acid, or sulphur.

On the other hand, several physicians who have had considerable experience in the wards of the fever hospitals, say that they have noticed very little difference between the mortality of patients so treated, and those treated constitutionally. Speaking at the Hunterian

Society this year, the Superintendent of the Eastern Fever Hospital said that during his tenure of office the medical officers had each had a pet remedy, which had been systematically tried. The results of these varying treatments, applied to a large number of cases, had not affected the mortality to any appreciable degree.

The alternative has been, therefore, merely to treat symptoms as they arise, and to endeavour to keep up the patients' strength with nutritious food, and to exhibit strychnine or digitalis p.r.n.

Of late years the study of bacteriology has brought out in strong light the fact that certain animals are immune from certain diseases. We know also that those who have had measles, scarlet fever, or small-pox are thereby rendered relatively immune from a second attack. Why is this?

You will remember that rats and mice are very little affected by the bacillus diphtheria, whereas guinea-pigs quickly succumb when inoculated. There must be some difference, then, in the resisting power of the tissues or blood of these animals toward the same micro-organism and its toxins. This difference appears to be in the serum of the blood, and if we could transfer some rat's serum into a guinea-pig the latter would show more resistance to the poison. But there is a further alternative. Since it is the case that a person who has had scarlet fever will be unlikely to contract it again, would it not be possible to inoculate a guinea-pig with just sufficient diphtheria virus that it would survive, and would that guinea-pig not be now immune from diphtheria? Given an immune guinea-pig, would the introduction of his serum into the system of a susceptible one protect the latter against the disease? As the result of careful experiment, this has been done. The toxin of diphtheria has been injected in very small quantity with iodine into a guinea-pig, and the reaction carefully noted; when the disturbance subsides, a further inoculation is made, and subsequent ones until the reaction is practically nil. At this point the guinea-pig is inoculated with a virulent culture of the bacillus with no result: the control animal—*i.e.*, a guinea-pig not rendered immune—dying in from 48 to 60 hours. Such is the rationale of the antitoxine treatment of the disease in man.

The serum of horses has no deleterious effect when injected subcutaneously; a horse is therefore rendered immune, and the serum injected into the subcutaneous tissues of a patient suffering from diphtheria.

To this end, bouillon is sterilized, inoculated with the Klebs-Löffler bacillus, and placed in a current of moist air, at a temperature of 37° C. for three weeks; the resulting liquid is freed by filtration from the bacilli, and kept in well-filled stoppered bottles in the dark. A healthy horse is then inoculated with this liquid, at intervals of a day or two; beginning with 1 cc. and gradually increasing the quantity. After a time, the horse fails to react to the inoculation of a virulent culture, and its serum, if mixed with forty times its bulk of the broth, fails to produce œdema when injected under the skin of a guinea-pig. The antitoxine is now ready for use.

The method of exhibition consists in injecting a quantity up to 20 cc. of the serum under the skin of the patient, at the side of the abdomen. If the symptoms do not abate a further 10, 15 or 20 cc., are injected the following day, and again on the third day if necessary.

This treatment has been extensively tried in Paris, at the Hospital for Sick Children, and the mortality has certainly been reduced. Roux tried it in 448 children, and had a mortality of 49 per cent. During the same period, the mortality among children suffering from diphtheria at the Hospital Trousseau was 86 per cent., and that at the Hospital for Sick Children during an equal period when the antitoxine treatment was not tried, was as high as 73 per cent. Roux further claims that it affects the disease itself, and points out—

1. The general condition begins to improve very rapidly (provided the antitoxine has not been administered too late).
2. The characteristic pale, haggard face gives way to a cheerful expression.
3. The duration of the disease is curtailed.
4. Complications are rarer.
5. The membrane ceases to grow, becomes detached, and cultivations of the Klebs-Löffler bacillus are not obtainable from the throat after the sixth day.

In England the experiments with it were not very successful. This was due the fact that the supply of the antitoxine being limited, it was only tried, as a rule, in very bad cases, and probably in nearly every such case late in the disease. Roux points out that it seems to be no use unless administered before the urgent symptoms have made themselves evident. Then, when physicians were wanting to try the remedy on more suitable cases, the horse took it into its head to die, and the supply ceased.

The possibility of a certain diagnosis early in the disease, coupled with a remedy which has reduced the mortality of all cases, mild and severe, from 73 per cent. to 49 per cent., give promise of results so startling, that one begins to wonder whether in a few years diphtheria may be relegated to the text-books with typhus fever and the plague, at any rate as far as the western countries are concerned.

In conclusion, I must express the honour I feel in having been permitted to read a paper before your learned Society.

In the discussion which followed, Mr. PARRY asked what were the indications for a second or third inoculation of the antitoxine, and thought that some method should be discovered to enable a diagnosis to be made in two hours.

Mr. A. V. CLARKE inquired whether antitoxine had any baneful influence on healthy individuals, and whether methylene blue had any local influence.

Mr. HOVENDEN seemed disinclined to believe that cats had the disease.

Mr. SHORLAND asked how it was that there was such a difference between the doses of antitoxine given, some giving 2 cc. and others 20 cc.?

Mr. HARNETT wondered what the influence of gastric digestion would be upon the tox-albumoses.

Mr. PENDRED would have liked to hear what were the relative advantages of antitoxine in adults as contrasted with children, and thought that the higher temperature in follicular tonsilitis might be of greater value than Mr. Pakes thought.

Mr. EYRE cited eight cases under his care where diphtheria had brought on menorrhagia.

Mr. BEDDOE thought the subject was a very important one, as medical men were so disadvantageously placed as regarded chances of inoculation.

Mr. KEY wanted to know what the action of paraffin on the membrane was.

Mr. ANDERSON alluded to the modern origin of the disease, and asked for an explanation.

Mr. COLEMAN had seen a case where membrane was present on the soft palate, but which cleared up entirely in three days.

Mr. PAKES having replied, the meeting terminated.

Guy's Hospital Auxiliaries Mess.

THE first of what promises to be an annual reunion of the Volunteers of this Hospital was held at the Moorgate Hotel on Friday evening, October 26th. The dinner was excellent, and about forty—the majority of whom were in uniform—did full justice to it. Among those present were Lieut. Luce, 2nd Wilts, in the chair; A. D. Fripp, Esq.; Surg.-Capt. Hayes, Adjutant Volunteer Medical Staff Corps; Lieut. Desprez, 2nd V.B. Kent Artillery; and Lieut. Tilbury-Brown, 1st V.B. Kent Artillery; and the following Corps were represented:—Hon. Artillery Company, Artists, London Rifle Brigade, Volunteer Medical Staff Corps, 2nd V.B. Wilts Regiment, 1st and 2nd V.B. Kent Artillery, and 1st V.B. Leicester Regiment.

At the conclusion of dinner, the health of Her Majesty having been duly honoured, Mr. Tom Godfrey opened the musical part of the programme with an original pianoforte solo, and later on gave two canteen songs, both original, and consequently excellent. The following gentlemen also contributed their services, and we regret that lack of space prevents us from giving them their due praise, Messrs. Keall, Evans, Frank Godfrey, Harrison (mandoline), Michael and Scott-Turner (banjo). Mr. Fulham-Turner gave the toast to the Visitors to which Mr. Fripp responded, and Mr. Michael proposed the Regular Forces, coupled with the name of Surg.-Capt. Hayes, this toast being drank with musical honours. In his reply, Surg.-Capt. Hayes told us, among other things, that in case of war the Volunteer Medical Staff Corps would be the first Volunteers called out. Auld Lang Syne brought to a conclusion one of the most enjoyable evenings at which it has been our good luck to be present.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

J. D. C., CHINGFORD.—Tubercle bacilli were not recognised in sputum.

W., BATH.—The specimen has a smoky colour and is acid, sp. gr. 1018. Trace of blood and albumin present. Tubercle bacilli were not found. There are numerous bladder-cells and a few granular casts. Some pus corpuscles and crystals of oxalate of lime were apparent.

R., HADLEY.—Specimen, sp. gr. 1032. Albumin, sugar, or blood were not found. Urea is not diminished in amount, while amorphous urates are present in some quantity.

R., TUNBRIDGE WELLS.—Specimen has sp. gr. of 1018. A trace of albumin is present, but no blood or sugar. No casts were found. Urea is not diminished in amount.

H., NORTHAMPTON.—The abscess wall did not involve more than the theca of the cord, and is of tuberculous character, though no tubercle bacilli have been found in it.

M., SALFORD.—1. The growth from the ear is that of an aural polypus.

2. The naso-pharyngeal growth was unfortunately not sufficiently prepared to enable a definite opinion to be formed. Kindly forward another fragment preserved in 50 per cent. spirit, with a few clinical details of the case.

PATHOLOGIST.

Appointments.

BRODRICK, C. C., L.R.C.P., L.R.C.S. Edin., has been re-appointed Medical Officer of Health to the Tavistock Sanitary Authority.

CRESSY, GEORGE JOHN, L.R.C.P., L.R.C.S.I., has been re-appointed Medical Officer of Health to the Warsop Local Board.

HODGSON, V. J., has been re-appointed Assistant Medical Officer of Health to the Port of London.

Sport.

Rugby Football.

GUY'S AND ST. THOMAS'S v. CARDIFF.

The first game of the Welsh tour of the combined Surrey-side Hospitals was played against the famous Cardiff Club, who had a strong team, on October 27th. The score of three goals against the Hospitals hardly indicates the evenly contested game which resulted. Tries for Cardiff were obtained by Norman Biggs (2) and T. W. Pearson, the former gaining the major points by magnificent place-kicking. Teams:—

GUY'S AND ST. THOMAS'S.—Back, K. B. Alexander; three-quarter backs, F. Rae, F. C. Wetherell, W. H. Thorman and H. T. S. Bell; half-backs, A. Montague and A. Rotherham; forwards, F. Bingham, G. H. Dominy, R. Rouillard, A. Thompson, A. E. Elliott, H. W. Dudgeon, E. R. Nicholson, W. Tyson, and R. S. Rowlands.

REMARKS.

[By "Welsh Athlete," in the Cardiff *Evening Express*.]

Whilst making every excuse for the slippery condition of the ground and ball, the game could not, by any stretch of imagination, be called an interesting or scientific one. For the greater part of it was a loose scramble in which any advantage gained by either side was as much the result of good luck as good management. In the tight packs, the Cardiff forwards held a slight advantage, but in loose work the Hospitals were, if anything, a bit the sharper. On the Cardiff side, Elsey was undoubtedly the smartest of the Cardiff eight; indeed, he was probably the best man on the field. One or two of the Hospital eight were smart in following up, but I was unacquainted with their names. At half-back, Biggs and Sweet-Escott were much superior to the opposing pair, and gave many chances to their backs which ought to have been utilised. The quartette, however, gave a very ragged display. They seemed quite unable to hold the ball, whilst the passing was, on the whole, very erratic. The Hospitals' four had not much to do in this direction, and Bell, whom we know to be a real good 'un, was fed very little, the greater part of his work being defence. Alexander, the Hospitals' back, played a particularly smart defensive game, and saved several tries in fearless fashion. Morgan improves every match. He never made a mistake, fielded in perfect fashion, and again showed his ability to get in his return under the most awkward circumstances.

POINTS OF THE GAME.

3.8.—Hospitals kicked off.
3.20.—A try for Cardiff—converted.
3.35.—A minor for Cardiff.
3.50.—Half-time called, with the score: Cardiff, one goal and one minor; Hospitals, nil.
3.53.—Cardiff re-started.
4.11.—A try for Cardiff—converted.
4.21.—A third try for Cardiff—converted.
4.30.—Time called, with the score: Cardiff, three goals and one minor; Hospitals, nil.

GUY'S AND ST. THOMAS'S v. SWANSEA.

Continuing their Welsh tour, the combined Hospitals met the Swansea team on Monday, and after a rough and scrambling game were defeated by a try (3 points) to nil.

GUY'S v. EAST SHEEN.

This match was played at Richmond on Wednesday last, and resulted in a win for the Hospital by two tries (6 points), obtained by Bell, to nil.

GUY'S 2ND XV. v. STREATHAM "A."

This match was played at Streatham on October 20th, and resulted in a win for Streatham by 1 goal and 4 tries to nil. Owing to the large number of first and second team men on the sick list, we took down but a weak team, and with M. P. Jones damaged after a quarter of an hour's play, we were no match for our opponents outside the scrimmage, who showed some good combination. Losing the toss, we started up a considerable hill, and were soon driven back into our own 25. A couple of long dribbles by Jones took the ball up to the other end, but we were soon on the defensive again, and in spite of the excellent tackling of Walling, one of their backs scored, but no goal resulted. We continued to have the worst of the game, and before half-time they added two more unconverted tries. Jones, who received a kick on the head, had to retire, and this enabled their half-backs to do pretty well what they liked. Playing down the hill we had somewhat more of the game, and Tom Morgan making a good opening for his namesake, the latter got well away and almost scored. Some smart passing among the Streatham backs resulted in a fourth try, which they converted, and to this they added another without much trouble, our defence having seemingly collapsed. Time saved us from any heavier beating, and we tramped back to the "Pied Bull" Inn in a drizzling rain, well in keeping with our spirits. We were chiefly beaten outside, our defence and attack being equally feeble. Tom Morgan and Kinsey-Morgan did their best in the centre, while Walling tackled very well, but the others made no attempt to delay any opponent's passage. Of course, Jones being hurt made a lot of difference. Our forwards, of whom Goddard, Pern and Rowe worked hard, ought to have carried the scrummages instead of only holding them, and made but feeble attempts at screwing. However, let us hope the Second have not forgotten their past records, and let us see some more dash and determination about their play, in place of the half-hearted pushing and tackling of the last two matches. Team:—

GUY'S.—H. B. Walling (back); T. Morgan, Kinsey-Morgan, A. H. Bell and Wilson (three-quarters); W. L. Stewart and M. P. Jones (half-backs); E. G. Goddard, A. H. Saward, H. Pern, G. Shorland, A. T. Falwasser, W. F. Lindsay, A. Rowe and F. Walker (forwards).

GUY'S 2ND XV. v. KENSINGTON 2ND XV.

Played at Honor Oak Park on October 27th, and resulted in a win for Guy's by 2 goals and 4 tries to nil. Winning the toss, we started with a strong wind in our favour and were soon attacking. A round of passing ended in Barrow scoring in the extreme corner, but no goal resulted. We continued to press, and Barrow again got over, but lost the ball. Hicks, however, presently scored right in the corner, but the place kick was again unsuccessful. Thorpe got over next, and Cleveland converted. Continuing to have all the best of the game, Barrow got in after some good passing, but the kick from near the touch line was again a failure. Just before half-time, Thorpe got over the line but was held. With the wind in their favour, Kensington had more of the game, and several times Walling had to defend. Hunter and Rowlands headed a good forward rush down the ground, and Ransford presently scored, but no goal resulted. The game now became rather scrambling in nature, our forwards not heeling out very cleanly. Tom Morgan taking a pass, cleverly ran in between the posts and kicked a goal. Nothing more was scored, and we won as stated. We were stronger than our opponents at all points of the game, but our forwards played with much more dash than in the two former matches. Hunter, Saward, and Goddard were the pick. Outside, Thorpe ran well, and all our three-quarters passed much better, although the greasy state of the ball rendered accurate passing difficult. Let us hope the Second will keep up this way of winning matches, as with thirty-one points against us in two matches, we have made a very bad start. There is still a tendency among the forwards to screw without the ball, and the marking out of touch might be more accurate. The outsides must not wait till they are collared before they pass, and it is no good passing to a man who is surrounded. Team :—

GUY'S.—H. B. Walling (back); T. Morgan, W. H. Barrow, A. C. Ransford and Kinsey-Morgan (three-quarter-backs); H. T. Hicks and R. S. Thorpe (half-backs); A. J. Cleveland, P. W. Hunter, E. G. Goddard, A. H. Saward, M. D. Wood, T. N. Gardiner, R. J. Rowlands and H. V. Bagshawe (forwards).

Association Football.

GUY'S v. BECKENHAM.

On Saturday, October 20th, Guy's met a strong team at Beckenham, and after a scrambling and exciting game defeated them by one to nil. The play does not merit much description, as it consisted of periodical rushes from end to end of the ground. The Beckenham forwards puzzled the opposing halves, but from their very trickiness missed several opportunities of scoring. The Hospital front rank were never together at any part of the game, Stamford being the only one who played up to form, while Fitz-Hugh kicked the only goal of the match, after a run by Mandy. For Beckenham, Simpson, Joy and Tyson played best, while Stamford, Crosby and Carter were most conspicuous for Guy's.

GUY'S v. CHATHAM.

Played at Chatham on Wednesday, 24th October, and resulted in a creditable win for Guy's by 5 goals to 4, after a fast and exciting game. The ground was in a very swampy condition, besides which there was a strong wind blowing straight down the ground, accompanied by drenching showers.

Guy's won the toss, and Chatham kicked off with the advantage of wind and hill, and soon gained the upper hand, but from erratic shooting and the fine defence of our backs were kept from scoring for some time. About twenty minutes from the start, the homesters obtained their first goal—a very doubtful one, as Barker was fouled by a forward, and in consequence was stunned for a few minutes; in fact, he was in a dazed condition for the rest of the first half. The home forwards again attacked, and six minutes later added a second goal from a fine shot. This put the Guy's men on their mettle, and the forwards now began to play a fine passing game (for the first time this season), and Mandy scored a feeble goal with a long shot. Almost immediately after, Fitz-Hugh made a fine single-handed run from the half-way line, and scored our second goal with a very good shot. From this point until half-time Chatham had all the game but could not score, although they had many opportunities. The whistle sounded for half-time with the game 2 all, though the Chatham score must have been greater but for the brilliant play of Barker and the backs, Carter being especially prominent.

After the usual interval, Guy's started the ball, but the homesters again attacked strongly, and five minutes from the start obtained their third point from a bully in front of goal. Guy's for the next twenty minutes had all the game, and Fitz-Hugh made the scores level, with a low shot, after a fine bout of passing between the forwards. Mandy soon gave us the lead, scoring the most sensational goal of the match by dodging the whole of the opponents' left wing, and running round the goal-keeper right into the net with the ball. This was soon followed by a fifth goal from Stamford, after a fine bit of passing.

Chatham now played for all they were worth, and within five minutes of time got their fourth goal, and must have scored again but for the brilliant defence of Barker and Carter. When the whistle sounded, Guy's were left victorious by 5 to 4.

Our forwards have at last learnt what combination means, and we hope they will not forget it. Their display was the feature of the match. Humphrey was a decided improvement on Pearson; but Palmer must learn to go off with the ball directly he receives a pass, instead of playing with it between his feet until his opponents are upon him. He has the making of a very good forward, if he will buck up. The half-backs were very good, but Crew must not rush at his man so much. The backs, as usual, were brilliant, but Lidderdale must remember not to kick too high in the air, as by so doing

he gives his opponents time to mark their man. Barker, n goal, played a very safe game, but still has a lot to earn.

Before concluding, let us here take the opportunity of expressing our hearty thanks to Dr. and Mrs. Buchanan, who, with characteristic Guyite hospitality, entertained the team at lunch, and looked after their comfort in every possible way, both before and after the match. Their kindness will always cause our first visit to Chatham to be looked back upon with the keenest possible satisfaction. Team :—

GUYS.—H. M. Barker (goal); A. B. Carter, F. J. Lidderdale (backs); H. Hewitson, E. J. Crew, A. E. Crosby (half-backs); P. S. Mandy, W. G. Palmer, R. T. Fitz-Hugh, R. B. Stamford, L. Humphry (forwards).

GUY'S v. BEXLEY.

Played at Honor Oak on October 27th, when Guy's won by 5 goals to 3. Guy's kicked off against a strong wind, and about fifteen minutes from the start Bexley scored after a good combined run. This was soon answered by Fitz-Hugh kicking a goal for Guy's, after a nice piece of work. Bexley again scored from a rush down the field, but the advantage thus gained was at once neutralised by Stamford landing the ball in the net at the other end, after a rally in front. Bexley scored again almost immediately, but Guy's were not to be denied, and as a result of some fine passing, Fitz-Hugh equalized and Palmer placed Guy's one ahead. At half-time the scores were 4—3 in Guy's favour, and as they now had the wind behind, it was thought they would score heavily. However, the forwards went to sleep for a time, and the Bexley goal-keeper defended his charge spiendidly, so that it was within ten minutes of time before the last goal was got for Guy's by Humphry. Bexley played hard right up to the finish, but were unable to increase their score, so that Guy's won as stated.

As the Surrey Cup Tie is so close, a few remarks on the play will not perhaps be out of place. The forwards pass well and shoot fairly, but are rather slow in getting on to the ball, and do not mark their men well at the throw-in. They must not slack off at the beginning of the second half, and should come back when the ball is near their own goal. The halves are (with the exception of Crosby) weak. Crew rushes too much, and does not get into his man quickly enough. Walker kicks too hard, and without knowing where the ball is going, while neither of them keep close enough up behind the forwards.

GUY'S 2ND XI. v. ST. MARY'S HOSPITAL 2ND XI.

This match was played at Honor Oak Park on Saturday, October 20th, and resulted in a win for us by 6 goals to nil. We won the toss, and defended the goal at the Pavilion end of the ground. For the first ten minutes play was fairly even, but about a quarter of an hour from the start we began to press, and Edey scored our first goal. Almost immediately after this, Thornley headed through from a corner, and thus notched our second point. Brookhouse scored again soon afterwards, and at half-time the score was 3 goals to nil in our favour. During the second half we pressed almost continuously, and scored three more goals (Edey, Miller, and Brookhouse). We scored during the game three other goals (Humphry 2, Brookhouse 1), but they were given off-side. Our forwards played well and showed good combination, and our defence was good, Thornley being prominent at half-back. The team was as follows :—

GUY'S.—J. Mules (goal); T. P. King and F. J. Jones (backs); R. Hayes, M. Thornley, H. A. Higgens (halves); L. Humphry, C. S. Brookhouse, E. J. Davis, A. Miller and R. G. Edey (forwards).

University of London.

THE BROWN ANIMAL SANATORY INSTITUTION.

(*Under the Government of the University.*)

NOTICE is hereby given that a course of *Five Lectures*, as required by the Will of Mr. Brown, will be delivered by the Professor-Superintendent (Dr. C. S. SHERRINGTON, M.A., F.R.S.), as follows :—

I. NOTES ON RABIES; at 5 o'clock on *Tuesday, November 6th*, at *the University, Burlington Gardens, W.*

II. THE BLOOD IN INFLAMMATION; at 5 o'clock on *Tuesday, November 13th*, at *the University*.

III. THE SENSORY APPARATUS OF MUSCLE; at 5 o'clock on *Tuesday, November 20th*, at *the University*.

IV. A DEMONSTRATION; at 5 o'clock on *Tuesday, November 27th*, in *the Laboratory of the Brown Institution*.

V. A POPULAR LECTURE to Working Men in connection with the Caius College Settlement in Battersea, on an evening in *December* not yet fixed.

THE LECTURES ARE FREE.

ARTHUR MILMAN, M.A.
Registrar, University of London.

October 25th, 1894.

Births.

CALDECOTT.—On October 9th, at Bracknell, Berks, the wife of Charles Caldecott, M.B., B.S. Lond., M.R.C.S., of a son.

SMALLPEICE.—On October 1st, at Queen Anne's Gate, the wife of William Donald Smallpeice, L.R.C.P. Lond., of a son.

Death.

HICKS.—On October 13th, at 7, Brock Street, Bath, Charles Cyril Hicks, M.D., of Wokingham, Berks, formerly of Dunstable, Beds, aged 62.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette.

NOVEMBER 17, 1894.

Popliteal Aneurysm.

CLINICAL LECTURE BY MR. DAVIES-COLLEY.

CASE 1.—W. H., æt. 30, a lighterman, was admitted under my care in January last, with a pulsating swelling in the right popliteal space. Patient had venereal disease twelve years ago. Three weeks before admission patient was thrown overboard by a rope which caught him around the leg. He only felt momentary pain. Six days before admission patient noticed a swelling under the right knee, which gave him no pain.

On admission.—There was a hard swelling, one and a half inches by half an inch, in the centre of the right popliteal space, which was pulsating. Pulsation was expansile. Pulsation could be felt in dorsalis pédis but not in posterior tibial. A bruit was to be heard over the swelling. Swelling did not quite disappear when the artery was compressed above at Poupart's ligament.

Treatment.—The femoral artery was compressed by the hand for twelve hours. Pulsation behind the knee gradually stopped and the patient's leg and thigh were bandaged with wool, the limb was raised and a weight left slightly compressing the artery for another twelve hours. The pulsation ceased and the tumour diminished in size until February 3rd, when the patient was discharged. On March 29th I saw him again, there was no pulsation, swelling smaller, and some pain when the man walked, which he felt in the back of the leg above the ankle.

CASE II.—W. P., æt. 50, a riveter, was first admitted for popliteal aneurysm in March, 1892. He had had gonorrhœa and rheumatism, and was subject to sciatica. Patient had had rheumatic pains in knee and ankle since the previous November. The swelling was four and three-quarter inches from above downwards, four inches from side to side, and three inches from before backwards. Border ill-defined. Circumference at upper border of patella sixteen and a quarter inches, as compared with thirteen and a quarter inches on the other side. When artery was compressed the tumour was still of large size, and circumference was diminished by one-quarter to three-eighths of an inch. There was a well-marked bruit.

During his stay I first tried digital compression and compression by weights, but without success. I then cut down on the superficial femoral artery at the apex of Scarpa's triangle, and ligatured it, using an aseptic silk ligature. He was discharged in June, and there was no recurrence of the aneurysm until nine weeks before the patient's admission in May, 1894. There was then the return of the pulsating swelling, with shooting pains in the leg, generally along the course of the external popliteal nerve. The tumour was found to be two and a half inches in length and three inches across. It felt hard, and there was slight pulsation which was not expansile. Pressure on the femoral artery above diminished the pulsation. He was put on Potassium Iodide, and the knee was kept flexed on the thigh. This occasioned him considerable pain, and digital compression was resorted to for twelve hours. The circumference round the knee at point of swelling measured fifteen and a half inches, and the pulsation was diminished. Subsequently patient was discharged wearing a starch bandage over aneurysm in June, and there was no pulsation. Patient returned under my care last October with a slightly expansile pulsating swelling as before, pain down the leg. The swelling measured five inches across and four inches in length. Circumference of thigh above patella sixteen and a half inches.

Popliteal aneurysm is the most common form which comes under the treatment of surgeons. The reasons why the popliteal artery is especially liable to this affection are the following:—

1. As it lies in close proximity to the knee-joint, the artery is continually being bent through an angle of nearly 180°.

2. The popliteal artery has no support from muscles.

3. Immediately below the space it at once divides into its several branches, so that there is greater pressure in the circulation here than higher up.

4. The popliteal artery is also in the lower extremity where the blood-pressure is increased by gravity. Similarly we find that varix nearly always occurs in the lower rather than the upper extremity.

The chief *cause* of an aneurysm is atheroma, which is a degenerative change in the deep layer of the inner coat of the large arteries. This change is generally attributed to chronic inflammation, set up by the strain to which these vessels are exposed during violent exertion. Syphilis also predisposes to this form of degeneration. Occasionally an injury may give rise to the yielding of the arterial coats, as in the first of the two cases I have read to you. Sometimes an aneurysm forms rapidly from the impaction of an embolus in disease of the cardiac valves. I once had to tie the brachial artery for one in the bend of the elbow. The patient was a sailor, æt. 25, and had had heart disease for many years, of such severity that he asked to have the operation performed without an anæsthetic. A few weeks before I saw him he had noticed a sharp pain in the forearm, and then a pulsating swelling had appeared. No doubt the wall of the artery had become inflamed from the contact of the mass of inflammatory material contained in the embolus, and had yielded to the pressure of the circulation. He made a good and rapid recovery, but died a year or two after from his heart disease.

The most common age for aneurysm to occur is in late middle life, when the arteries are beginning to get the worse for wear, while at the same time they are still exposed to the strain of severe muscular exertion. It is rare to get aneurysm in females, and when it does occur in them you will generally find that the cause has been syphilis.

Popliteal aneurysm is usually of the sacculated form. I should describe it also as a *true* aneurysm, meaning by that term that the walls are formed by one or more of the coats of the artery. There is, however, another mode of defining *true* as distinguished from *false* aneurysm, which seems to me to be impractical and useless.

Diagnosis.—There is a throbbing tumour in the popliteal space, and the patient complains of pain not only in the swelling but running down the limb. If it is of the sacculated form, it has generally a somewhat globular shape, terminating abruptly above and below. You should examine the pulsation carefully as to whether it can be felt all over the swelling, and whether it is of an *expansile* character. You will usually be able to hear a bruit if you apply the stethoscope. But I do not think this evidence of much value, as it is possible that a bruit may be caused by the pressure of a stethoscope upon a healthy artery.

There are various swellings which sometimes occur in the ham, and resemble aneurysm. If they pulsate you will generally find that the pulsation is not expansile, and that it is confined to a single point or line upon the surface of the tumour. Often, also, a change of the position of the limb will remove the pulsation.

You will find most difficulty in distinguishing aneurysm from subperiosteal sarcoma of the femur, but in most cases, although the latter has the heaving of an aneurysm, you will be able to make out that the swelling is much more diffused, and that it cannot be moved upon the bone underneath.

Press upon the artery and you will feel the tumour better; the pulsation will cease, and when the fingers are removed the swelling re-appears more slowly than in the case of an aneurysm.

Usually fluctuation does not occur in an aneurysm. The sac is lined with dirty grey material which consists of numerous layers of fibrin deposited by the blood. The presence of these layers prevents you feeling fluctuation.

Can you say by examining an aneurysm whether it is likely to be cured by pressure upon the artery above? I think you can.

Get some one to press upon the common femoral artery at Poupart's ligament, then notice whether the swelling in the popliteal space decreases in size. If it does much it will show that the cavity must be filled by fluid; if, on the other hand, the aneurysm remains the same size, you may be quite sure there is a great deal of clot, and that it is a favourable case for compression or ligature of the artery.

Termination of Popliteal Aneurysm.—Very few cases recover of themselves. They may get cured, however, in two or three ways; in the first place, if a patient keeps quite still, the interior of the sac may become full of laminated clot; or, again, the circulation in the aneurysm may be stopped in various ways. It may become so large that it presses upon the artery above the opening into the sac, or a clot may be detached from the aneurysm and stop up the artery below; or a clot has been known to come down from a second aneurysm higher up the artery and so stop the circulation in the sac. Inflammation may also occur around the aneurysm and produce a still further clotting in the sac; and if a patient gets over the risk of secondary hæmorrhage, etc., he may have the aneurysm completely cured in this way.

But much more often the aneurysm goes from bad to worse, and may end in several ways. One is for the aneurysm to burst externally, and the patient to die from loss of blood; more often it bursts internally, when it is said to become diffused; or gangrene may occur and destroy the limb; or suppuration of the sac may take place and give rise to abscess, secondary hæmorrhage or gangrene.

Treatment.—To begin with, the patient must be kept at rest in the recumbent position. He may also adopt the medical treatment by diet and drugs, to which one is

almost completely restricted in the case of aneurysm of the thorax and abdomen. That by diet, Tufnell's, as it is called, consists in the limitation of solid food to ten ounces daily, of which three should be meat, and of liquid food to eight ounces. Iodide of Potassium is the drug which we most rely upon, partly because of the syphilitic origin of some aneurysm, and partly because of some influence which it is thought to exercise upon the coagulation of the blood within the sac. In popliteal aneurysm, however, we do not trust much to these remedies, as we can act more directly upon the circulation in the sac by pressure or ligature of the arteries above.

Complete flexion of the knee is the first method of compression which I usually adopt. By this plan the aneurysmal swelling is made to press upon the artery above and so impede the circulation. It is easily applied, but I have found that in a large majority of cases it is unsuccessful.

The next method is that of digital compression. For this you require a great many assistants, who will apply pressure for half-an-hour or so at a time to the common femoral artery as it passes under Poupart's ligament. By this means you can limit your pressure to the artery, and, as it lies at this point upon the bony ridge of the horizontal ramus of the pubes, you can stop the circulation with a smaller amount of force than elsewhere. You will find, however, that the muscular effort required is considerable, and I should advise you to put a soft pad over your fingers (a tobacco pouch does very well), and to use a weight of about ten pounds on the top of the pad. When you have had your turn of compression, and are handing over the task to your successor, take care to have a tourniquet such as Signoroni's, and apply it to the artery at the apex of Scarpa's triangle. I think that twelve hours of digital compression is usually enough. If the circulation stop in the sac you must go on pressing for some time longer, for the clot is a soft one, very different from the laminated deposits already existing in the sac, and the force of the blood-stream may easily wash it away. In the first of the cases I have read, this method was quite successful, and I am much indebted to the twelve or more gentlemen who devoted so much time and exertion to the cure of my patient.

Reid's plan is somewhat similar, in which the circulation is stopped by the pressure of an elastic bandage below and above the aneurysm. In many cases it has been successful. In some, however, gangrene has followed, apparently because the clotting was not confined to the sac but had extended to the popliteal artery as well. Hence the plan has of late fallen into disuse.

Now we come to treatment by ligation of the artery. This method in some form has been employed since the time of Celsus. But a good many cases operated on in this way died, and amputation was preferred by many surgeons. Then you know the great improvement introduced by J. Hunter, of tying the artery at some distance above the aneurysm. He tied it in Hunter's canal, and the advantage claimed was that the artery was not likely to be diseased as in the neighbourhood of the aneurysm. Another advantage was that the operation was not so near the sac; so that you avoided one of the great dangers, viz., that of producing suppuration in the sac with all its attendant troubles. That treatment has been adopted ever since with the slight modification that the artery has been ligatured in the place most easy to get at, viz., the apex of Scarpa's triangle. Of late, however, surgeons are beginning to think that the change has not been a good one, and I am inclined to think so myself, because there is a danger of the collateral circulation being too free and proper coagulation not taking place. When we operate aseptically we need have little fear of setting up suppuration of the sac, so I am disposed to think that the ligature should be applied in Hunter's canal, or even in some cases as low as the upper part of the popliteal space.

I ought to say that some surgeons advise resorting at once to ligature. They say digital compression produces unfavourable conditions for ligature. I do not think so myself, but rather that by digital compression the collateral circulation is improved, so as to diminish the risk of gangrene.

Generally I should adopt the ligature in cases where I had employed flexion and digital compression without success, but there are cases in which I should apply it at once—viz., in which the aneurysm was growing rapidly with great pain, and with very little tendency to the formation of laminated clot. What should the ligature consist of? For a long time we used catgut ligature of the ordinary kind or hardened with chromic acid. But as I have twice had to operate again after using it—once because the ligature was absorbed and the artery became again patent, and another time because a second aneurysm appeared where I had applied my ligature—I prefer now to use the silk ligature. Formerly this was rather dangerous. It was left long, and formed a sort of seton dangling from the wound, but now we make the ligature carefully aseptic by boiling and keeping it in solution of carbolic acid. We tie it tightly round the artery and cut it short. The wound heals by primary union, and we see nothing more of the ligature.

Then comes the question of recurrence. In one of my cases, after the ligature of the superficial femoral artery at the apex of Scarpa's triangle, the pulsation returned in the aneurysm. It is not always a bad sign to have some pulsation recurring. It shows, at any rate, that there is no risk of gangrene of the limb. Not unfrequently some is noticed a day or two after the operation. Soon the aneurysm swelling becomes hard and the pulsation ceases. In this case, however, the aneurysm returned to its original size and there was great pain in the back of the leg. I do not know what the cause of this recurrence was. It may have been because I tied the artery at the apex of Scarpa's triangle and the collateral circulation was too free, or the man may have gone to work again too soon after treatment. Then there is another reason quite possible. Although the aneurysm was of a globular character it may not have been a sacculated, but a fusiform aneurysm. In the

latter case you can understand how difficult it is for a hard clot to form. I have on the table a preparation from the leg of a patient with popliteal aneurysm, for whom I ligatured the superficial femoral artery six years ago. The patient went back to his work cured, for three years, then came here with breathlessness and very ill with aortic disease, and died from that cause. You will see that the aneurysm was of a fusiform character, and that it was never thoroughly obliterated.

What are you to do when all the symptoms of aneurysm recur after ligature of the artery at the apex of Scarpa's triangle? One plan is to adopt the method of Antyllus, viz., to tie the artery above and below, incise the sac, and turn out the clots. I had to do this once in a case of a seaman with a traumatic aneurysm in Hunter's canal. This had been treated at Copenhagen by ligature of the superficial femoral artery at the apex of Scarpa's triangle. I tied the artery above and below, and laid open the aneurysm, and I had a lively time for a quarter of an hour, all the arteries spurting together, and it was with great difficulty I could tie them and control the hæmorrhage. I must say I should fear very much to perform this method of Antyllus in a case of popliteal aneurysm, because the popliteal artery is very differently situated to the superficial femoral, and there would be considerable danger of injury to other important structures, and especially to the popliteal vein.

Then there is amputation; but that seems unnecessarily severe to cut a man's leg off when he is only 50 years of age and able to work.

We began by trying flexion, and afterwards digital compression for twelve hours, and we did a great deal of good by that. The pulsation almost disappeared, and the patient went out with a cotton-wool and starch bandage upon the limb. He returned to work and seemed all right; but he came back again a month ago with the aneurysm as big as ever. It was, therefore, necessary to do something more, and I thought the best thing was to ligature the artery at the lower end of Hunter's canal. One reason I had for adopting that plan was that I found that by pressing there I could stop the circulation in the aneurysm. There was, however, a fallacy in this observation, as I could not be sure that I was not compressing some other artery as well as the superficial femoral.

However, it seemed to me better in a case like this to do too little than too much. I therefore ligatured the superficial femoral artery as low as I could in Hunter's canal. The pulsation ceased or very nearly ceased at time of the operation. The patient was kept with cotton-wool round the limb, and the limb kept still with a starch bandage, and I dressed it on the tenth day. It was all healed up, but there was still a little heaving pulsation in the swelling. I dressed it again the other day, and there is still this heaving pulsation, and I suppose I shall have to do something more. My present intention, if the pulsation still goes on, is to cut down upon the lower half of the popliteal space, and try if I can expose the artery and tie it there.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	7.	Aortic and mitral regurgitation. Anæmia. Old right hemiplegia.
	14.	Aortic regurgitation and ? Mitral stenosis.
	15.	Chlorosis.
	16.	Ulcerative endocarditis.
	19.	Aortic and mitral regurgitation.
	30.	Chlorosis.
	35.	Transposed viscera.
	42.	Chlorosis.
	48.	Aortic and mitral regurgitation.
	49.	Mitral stenosis and regurgitation.
Philip	1.	Mitral stenosis and regurgitation.
	8.	? Thoracic aneurysm.
	13.	Thoracic aneurysm.
	36.	Mitral regurgitation.
Stephen	6, 14.	Mitral regurgitation.
	18.	Mitral stenosis.
	25.	Aortic regurgitation. Mitral stenosis and regurgitation.
	33.	Mitral regurgitation.

Nervous System.

Mary	6, 31, 40.	Chorea.
	9.	Paraplegia. ? Hysteria.
	12.	Cerebellar tumour. Optic neuritis.
	20.	Paraplegia. ? Early peripheral neuritis.
	32.	Paraplegia. Secondary growths in spine.
	33.	Fits. Vomiting. Secondary growths in brain. Old scirrhus mammæ.
	47.	Right hemiplegia and aphasia. Cerebral syphilis.
Philip	5.	Malarial neuritis.
	10.	Right hemiplegia. Aphasia.
	14.	Fits. ? Tumour. ? Epilepsy.
	15.	Right hemiplegia.
	29.	Sciatica.
Stephen	9.	Paraplegia. ? Spinal caries.
	10.	Paraplegia.
	12.	Cerebral tumour. Optic atrophy.
	17.	Paraplegia. Myelitis.
	21.	Peripheral neuritis.

Alimentary System.

Abdomen.

Mary	1, 2, 10, 28.	Gastric ulcer.
	21.	Enlarged spleen. Ascites. Anæmia.
	23.	Abdominal pain and vomiting. ? Carcinoma of stomach.
	24.	Neurotic dyspepsia.
	38.	Dysphagia. Œsophageal growth.

PHILIP 3. Enlarged liver and spleen. Obstruction of inferior vena cava.
12. Hæmatemesis. Cirrhosis of liver.
17. Ascites. ? Perityphlitis.
27. Perityphlitis.
STEPHEN 4. Ascites. Cirrhosis of liver.
39. Carcinoma of stomach.

Typhoid Fever.

MARY 8, 35, 36, 37, 45, 50.
PHILIP 6.
STEPHEN 19, 34, 37.

Genito-Urinary System.

MARY 5. Chronic tubal nephritis.
18, 34. Diabetes mellitus.
22. Chronic interstitial nephritis. Hypertrophied and dilated heart.
43. Chronic nephritis. Ascites.
PHILIP 4. Nephritis. Pericardial and pleuritic effusions.
11. Diabetes mellitus.
19. ? Renal calculus.
21. Diabetes. Phthisis.
22. Chronic tubal nephritis.
25. Acute tubal nephritis.
38. Chronic tubal nephritis.
STEPHEN 24. Diabetes. Delusions.

Respiratory System.

PHILIP 2. Hæmoptysis. Dysphagia.
20. Pneumonia. Left base. Systolic apical bruit.
23. Bronchitis and emphysema.
32. Pleuritic effusion.
40. ? Phthisis. ? Chronic pneumonia.
STEPHEN 2, 14. Empyema.
5. Hæmoptysis. ? Phthisis. ? Bronchiectasis.
20. Lobar pneumonia.
27. Laryngitis.

Phthisis.

MARY 17, 41.

Miscellaneous.

MARY 4, 26. Raynaud's disease.
13. Anæmia. Wasting. Tubercle.
27. Acute rheumatism.
44. Psoriasis.
PHILIP 16. Acute rheumatism.
11. Lumbar pain. ? Cause.
STEPHEN 5. ? Addison's disease.
8. Chronic arthritis. Anæmia. ? Tubercle.
29. Acute rheumatism.
30. Acute rheumatism. Endocarditis and pericarditis.

UNDER DR. PYE-SMITH.

CASE OF THROMBOSIS IN A MESENTERIC VEIN WITH SECONDARY SLOUGHING OF THE INTESTINE.

Ernest J., æt. 18 months, a fat, healthy-looking boy, was admitted May 6th, 1894, for fever, sore throat, and dyspnœa. Nine months before he had had measles, but recovered perfectly. Present illness was first noticed three days before admission.

On admission.—Temperature, 101·4; pulse, 152; respiration, 40. The nostrils, fauces, and mouth were full of muco-pus. The tonsils were so much swollen as to be in contact with each other. No membrane visible. Urine normal. Neck much swollen. Submaxillary and superficial cervical glands inflamed and painful, especially on the right side. Stridor and forced breathing heard in chest. Nostrils syringed with Potassium Permanganate, mouth cleaned with Glyc. Boracis, and Belladonna fomentations to neck.

May 12th. Temperature varies between 99 and 103. Glands on right side seem going to suppurate. Stools offensive.

15th. Double otorrhœa appeared, at first thin and colourless, but a day or two later purulent and slightly offensive. Syringed with boric acid.

18th. Temperature has come down the last three days and is now subnormal. Otorrhœa has disappeared.

19th. Submaxillary glands on right side incised and ʒjss of greenish pus evacuated. Child happier and not so restless. Slept well. Tonsils very much better.

21st. To-day patient seemed ill. All day he was cold and could not be kept warm. He vomited several times. Evening temperature below 96. He was several times noticed to roll on to his stomach and fling himself about as if in pain. Brandy, ether and ammonia were given frequently. The abscess appeared to be progressing satisfactorily.

22nd. He did not sleep at all well. He was still cold, and several times vomited dirty green, bilious fluid. The abdomen was slightly distended. Later on it was at one time rigid, at another perfectly supple. Respiration, 60 or more; heart-rate, 150–60. Abdomen moved imperfectly in respiration. Resonant everywhere except in extreme flanks. At 11.30 p.m. he was worse, weaker and helpless. A hot bath was given. As soon as he was taken out of this, he was sick, and passed some blood-stained mucus. (The bowels had not acted for about 40 hours, the last motion being apparently normal.) The abdomen was supple, and no tumour could be felt there or per rectum. He sank and died at 1 a.m., May 23rd.

Autopsy.—The cervical glands were large, some of them caseous and some suppurating. The tympana, brain and membranes were quite healthy. On opening the abdomen there was recent lymph on the intestines, especially in the lower half of the cavity. Within the pelvis was a collection of several ounces of blood-stained mucus. On lifting away some of the coils, a loop of gut was seen overhanging the brim of the pelvis, three

inches in length, with its lower extremity five inches above the ileo-cæcal valve. The loop was of a deep purplish colour: it was perfectly soft, rotten and necrotic, though not stinking. In three places it had perforated, the rents having ragged flocculent edges. The mucous membrane appeared to have been destroyed over the inner surface of the loop. Further investigation showed that the tributary of the mesenteric vein draining the affected coil was filled with ante-mortem clot, extending into a vessel the size of a crow quill, but not blocking the main trunk of the superior mesenteric vein. The clot was pale and decolourised, adherent and quite firm. The neighbouring mesenteric glands were swollen, but not softened. The thrombus was clearly not of a septic or pyæmic nature. Above and below the affected loop the ileum was moderately distended and there was a pink mucus in the colon, exactly resembling the fluid passed an hour before death. The other viscera were normal, but anæmic.

Remarks.—The condition is an extremely rare one, which is barely alluded to, or ignored by the systematic writers.

The following specimens in the Guy's Museum illustrate it. No. 947, originally labelled *Congestion of Small Intestine.* The intestinal wall is thickened, and the mucous surface covered with shreddy exudation. The mesenteric veins are distended with thrombus. The history of the case is not forthcoming. No. 948. This is from the case described by Dr. Fagge (*Trans. Path. Soc.*, vol. 27, 1876, p. 124). The patient was a lady, æt. 34, who, while convalescent from phlegmasia dolens, was suddenly seized, a month after her confinement, at 6 a.m., with violent abdominal pain, vomiting of viscid blood-stained fluid; collapse; abdomen flaccid, no tenderness anywhere, nor unatural fulness. She died eleven hours from the onset of the seizure. The greater part of the jejunum was deeply congested and thickened, and contained a reddish fluid. The internal surface of the bowel was deeply reddened, and covered with shreds of inspissated mucus, so that it seemed as if the mucous membrane itself was being detached. The affected portion of intestine was not distended. The superior mesenteric vein and the trunk of the portal vein were distended with adherent clot. The inferior cava and its branches above the renal veins were also plugged. The vena cava was clearly far from normal before the thrombosis began. It was flattened, narrowed, and deeply imbedded in a quantity of very firm fibrous tissue.

No. 951, is from the case described by Sir Wm. Gull (*Guy's Hospital Reports*, vol. 42, 1884, p. 15). It consists of sloughed mucous membrane ten inches in length, in which the valvulæ conniventes are plainly visible, passed during life. The patient was a man of 23, who was thought to have contracted syphilis five months previously. Some days before there had been slight and transient œdema of the right hand and forearm, which was vaguely referred to this cause, but had cleared up. Whilst apparently in perfect health he was seized with severe abdominal pain, relieved by a warm bath, but followed by very profuse intestinal hæmorrhage. There was slight sickness, but no hæmatemesis. The blood varied in tint from black to a much lighter colour, indicating that the bleeding surface was extensive and high up. The patient was much relieved by the bath, feeling "as if something had been set free by it," which was probably due to the hæmorrhage. There was no fever. The urine contained a trace of albumin. Three days later he became suddenly collapsed and pulseless. Next day, temperature 100·8; abdomen tympanitic; constant vomiting; stools bilious without blood. He gradually improved, the urine coming to contain a quantity of albumin, blood, mucus and casts. Eight days after the onset he began to pass the rings of mucous membrane mounted in the specimen, and continued to do so for a week.

He gradually recovered, and four years later was able to travel about like a healthy person, though the urine still contained some albumin. The sudden onset, and absence of fever or previous illness, with the exception of transient œdema of the hand, pointed to a mechanical cause, and one obstructing the superior mesenteric vein high up. It was conjectured that the obstructing cause was outside the vessel and might be a gummatous deposit. It was expected that other veins in the neighbourhood, such as the renal, would also suffer, as subsequently occurred. Sir Wm. Gull was inclined to think that there was evidence of congenital syphilis in Dr. Fagge's case (No. 948), and that the affection of the connective tissue surrounding the abdominal veins was of this nature. The patient, who recovered, was therefore actively treated with iodide and mercury. Sir William Gull says: "The case suggests some thoughts as to therapeutics; the uselessness, if not harmfulness, of trusting symptoms. The profuse hæmorrhage would have seemed to call for styptics, yet the hæmorrhage was useful and curative, and drugs to stop it would have done nothing but harm. The hæmorrhage was a necessity of the conditions, and therapeutical. On the question of artificial depletion it supplies some lessons. Bleeding did good in this case at least."

Dr. F. Taylor has recorded a case (*Trans. Path. Soc.*, vol. 32, 1881, p. 61) which closely resembles the case under Dr. Pye-Smith. The patient, a delicate child, aged 5, was never seen by a medical man. She was suddenly seized one afternoon with very severe pain in the stomach and vomiting. This was attributed to some strawberries she had eaten. In the evening the pain was rather better, and she slept a little on going to bed. The pains, however, came on again violently during the night, and she screamed out, became delirious, and threw herself about. Towards morning she became faint and exhausted, collapsed and died at 7 a.m.

The abdomen contained a quantity of dark fluid blood. The small intestines were a dark blood-red colour, uniformly but not excessively distended, with the exception of the duodenum and upper ten inches of jejunum, which were pale and healthy looking. The

superior mesenteric artery was perfectly normal for an inch of its course; it was then "completely lost in an irregular-shaped mass of tissue three-quarters of an inch long, semi-cartilaginous above and fibrous below." The superior mesenteric vein could not be traced through this mass, but immediately above it it was obstructed by an adherent thrombus. The mesentery was thickened, and contained large fleshy glands. The intestine contained blood similar to that found in the abdominal cavity. The mucous membrane was swollen. A band was found crossing the small intestine, but it was lying quite loosely on it, and further examination precluded the possibility of strangulation due to this cause. Prof. Osler has observed three cases of *Infarction of the Bowel (Principles of Medicine*, p. 404). In every case it was the superior mesenteric *artery* that was obstructed. Case I. was a woman of 55; she was seized with abdominal pain, tympanites and vomiting, becoming incessant and fæcal. Case II. was a woman of 75; she was seized with pain, vomiting, and at first diarrhœa. Subsequently there was obstruction and great distension. Recent warty vegetations were found on the mitral valve. Case III. was a man of 40. He was suddenly seized with intense pain, became faint, fell down and vomited. For a week he had vomiting, diarrhœa, tympanites and great pain. The stools were thin and blood-tinged.

The autopsy showed an aneurysm of the aorta where it passes through the diaphragm, containing fibrous clot. Such infarctions are said to be common in horses. Obstruction of the mesenteric veins he has not alluded to.

Clinically, whether the obstruction is primarily arterial or venous, does not make any great difference in the symptoms. The existence of heart-disease or aneurysm is in favour of embolism, which may also be caused by particles of new growth or parasites. Thrombosis occurs under conditions of stagnation, atheroma, obliterative arteritis and aneurysmal dilatation, as the result of endo and periphlebitis, and hæmic changes.

The symptoms to which attention should be paid are the following: (1) *Sudden onset.* (2) *Intense pain* (the pain of distension by effused blood, as in dissecting aneurysm, is probably worse than that of any colic). (3) *Vomiting*, sometimes bloodstained or becoming fæcal. (4) *Severe collapse.* (5) *Distension* is not constant; it is less marked according as the lesion is higher up, severer and more acute. (6) *Tenderness* is the exception rather than the rule. *Rigidity* is exceptional; it was noticed in the first case on one occasion only. (7) *Diarrhœa* occurred in several cases, though it may be replaced later by obstinate constipation. fæcal vomiting and distension, which is not strange considering that a loop of intestine is completely paralysed. The character of the stools is of great importance, especially if they consist of bloodstained mucus, containing shreds of mucous membrane. (8) *The absence of fever*, at any rate at first. (9) The presence or absence of heart-disease, phlebitis, phlegmasia, aneurysm, and any cause which is known to be associated with vascular obstruction. In Dr. Pye-Smith's case no cause, either predisposing or exciting, could be found, nor even an "hereditary tendency." *A priori* one would imagine typhoid fever to be the ideal condition in which it would occur, what with stagnant circulation, toxic blood changes, and sloughing Peyer's patches. This child, however, was fat, healthy and restless, and the clot was not septic.

The diagnosis resolves itself into an examination of a few common and somewhat trivial symptoms.

Acute obstruction can only be distinguished by the action of the bowels, and the absence of definite tenderness or rigidity. *Intussusception* (which was suggested for Dr. Pye-Smith's case) is distinguished by the presence of an abdominal tumour. The fluid passed per rectum in such a case exactly resembles that described above—viz., pink mucus. If pieces of sloughed intestine are passed, they will contain muscular fibres as well as mucous membrane, whereas the sloughs in Sir Wm. Gull's case contained no muscular fibre. *Catarrhal enteritis* is distinguished by the relative preponderance of diarrhœa over sickness. The difficulty of diagnosis is illustrated by the following case:—William F., æt. 4, was admitted into John, under Dr. Perry, September 27th, 1894, with the following history:—Five days before admission he was drowsy and vomited. Attributing this to some nuts he had had the day before, his mother gave him some magnesia, which acted so much that all the next day he was passing blood and "rabbits' brains" (shreds of mucus), with severe tenesmus. The day before admission, the doctor who had been treating him for three days felt a tumour in the sigmoid region. Taking this to be an intussusception, he injected a pint of boric lotion into the rectum with a Higginson's syringe, under $CHCl_3$, whilst the boy was held up by the legs. The tumour disappeared. On regaining consciousness, the lotion was passed, and the tumour became again palpable. On admission, temperature 98, tongue furred, abdomen flaccid, and not particularly tender; resonant all over, no tumour to be felt. No further sickness occurred, but frequent passage of stools containing blood and shreds of mucus. The diagnosis lay between *intussusception* (partially or wholly reduced), *mesenteric thrombosis* and *catarrhal enteritis.* In any case it was clear that operation would be useless, and probably fatal. He was treated medically, gradually got better, and was discharged well on October 25th. The diagnosis was therefore probably *catarrhal enteritis.*

The other diseases which only need mentioning are (1) *acute peritonitis*, say, from perforation of a hollow viscus; (2) *fevers*, such as typhoid and dysentery (and ulcerative colitis); (3) varieties of *enteritis*, such as mucous disease and pellicular enteritis.

The *treatment* consists in preventing surgical interference.

A. J. S.

In the Surgical Wards.

Cases under Mr. Howse.

Charity	11.	Swelling in right axilla. ? Sarcoma.
Naaman	3.	Acute necrosis about neck of scapula.
	5.	Disease of shoulder-joint. ? Old dislocation. Rheumatoid arthritis.
	13.	Early hip-disease. ? Synovitis. ? Tubercular.
	17.	Enlarged thyroid. Removal of portion. ? Carcinoma.

Cases under Mr. Davies-Colley.

Luke	8.	Swelling in calf. Abscess.
	11.	Carcinoma recti. Inguinal colotomy.
	18.	Dysphagia. Malignant stricture of œsophagus.
Lydia	1.	Psoas abscess.
	4.	Calculous pyonephrosis. Removal of calculi.
	Cot.	Fluctuating swelling over ribs. Empyema. Operation.

Cases under Mr. Lucas.

Accident	4.	Hæmatoma in gluteal region. Run over abdomen. Hæmaturia.
	30.	Fractured ribs. Emphysema.
Charity	3.	Acute inflammation of patellar bursa.
	23.	Chromic abscess of breast. ? Tubercular or syphilitic.
	Cot.	Paralysis of bladder (overflow) and rectum. Spina bifida.
Job	3.	Mastoid abscess. Antrectomy.
	5.	Stone in bladder.
	18.	Carcinoma recti. Annular stricture. Obstruction.
	22.	Strangulated inguinal hernia. Colotomy.
Lydia	12.	Varicosed and thrombosed veins. Right external saphenous.
	15.	Varicose veins.
	16.	Lupus on buttock.
	Cot.	Congenital funicular hernia.

Cases under Mr. Golding-Bird.

Lazarus	4.	? Gummatous hip-joint disease.
	19.	Secondary syphilis.
	21.	Right inguinal bubonocele.
Martha	5.	Umbilical hernia.
	6.	Cleft palate.
	21.	Hip-disease.
	Cot.	Congenital double inguinal hernia.
	Cot.	Hare lip.

Cases under Mr. Symonds.

Martha	13.	Old lupus of nose. Malignant growth. ? Epithelioma.

Case under Mr. Golding Bird.

Total Suppression of Urine after Operation for Piles.

Lazarus.

8. Male, æt. 50. Healthy vigorous man. Was operated on for piles with the clamp and cautery. Urine before operation perfectly normal. The same evening he complained of pain and tenderness above pubes. At midnight he was moaning with pain. He got on to his hands and knees and passed ʒiv. of high-coloured urine. At 2 a.m. the next day he said he felt that his bladder was distended, but on a catheter being passed, ʒij. only of urine came away. After this no urine was passed. Every hour showed a difference for the worse in the patient. His pulse became rapid, his extremities cold, and despite profuse sweating produced by a hot pack and hot drinks, there was no change for the better.

There were no complications at the seat of operation. The man retained consciousness up to the very last. There were no twitchings or uræmic symptoms. He died thirty-eight hours after the operation. The post-mortem revealed no abnormal condition of the kidneys or other organs, and death was apparently due to total suppression of urine, produced reflexly by the operation on the bowel.

Advice Gratis!

As nearly every student of the fourth, or senior—or junior—year feels that he is about to become—or is already, though not duly recognized—a consultant of the first rank, it may be useful to give two or three hints as to the methods to be adopted that he may attain this distinction pleasantly and easily.

We cannot enter into the trivial question of the desirability of possessing one or more of the labels obtained through what are termed the "higher exams." —nor that of the necessity of waiting till years shall have bared the brow of the curled darling at present in the lap of his Alma Mater—nor even that of getting a tiny share of the common property of the ordinary consultant, a certain amount of special knowledge.

We can but give hints as to the course of conduct —not study—which will be found useful to the one who feels that in his fourth year all knowledge is his, and that he is too good for general practice.

Firstly, then, we would say, cultivate an eccentricity. The most suitable must ever be a matter for the individual, or it would cease to possess value as an eccentricity.

A careless lock that falls over a marble forehead, to be brushed back in moments of apparently profound thought, a dangling chain whose sinuous lengths may be woven into ideas by the busy fingers that symbolise the busy brain, a cough of momentous portent to take

the place of words in time of need, a frown of solemn grandeur or an attitude of quaint flexion or affected dignity to assist the cough in its invaluable function, —needless to further recapitulate the eccentricities that we have known to convey deep and wonderful meanings, inexpressible in language; meanings, that is, which have being only according to the will of the observer, and are cyphers in the consciousness of the eccentric consultant.

Secondly, cultivate a kindly air of the "Almost as well as I could have done it myself" sort. The duty of the consultant is more particularly to tell anxious friends how absolutely correct and trustworthy is the opinion of the general practitioner, whom he deigns to meet for a consideration. Therefore never forget the "Almost," and accentuate it in inverse proportion to the amount of the expected fee. Be gentle in your dignity, while never losing sight of the immeasurable gulf that separates you, the profound student, from the lowly family doctor, the poor creature who is part of the hearth and home of his patients. This is difficult, but leads to wealth, sometimes.

Thirdly, be guarded—we had almost said vague, but that were an indiscretion,—be guarded but definite in your prognosis. This is the chief faculty in the exercise of which, real knowledge—as it exists among fourth year's students—will be required. As an example, you may begin with a formula of this description, "One sees a good deal of this class of case." This is much used by the young consultant who wishes to advance rapidly; it reads differently with those who have climbed slowly, and the "One sees" is replaced by "I have seen," but their methods are of course obsolete. However, if conscience be well curbed, the "I have seen" may be used with surprising effect, and will give weight to the oracular dicta which follow, as for instance:—

"If the constitutional resisting power of our patient be such as to withstand the dangerous effects of his disease, we may look for a change for the better, unless, as sometimes happens, other circumstances should arise. I mean such as might possibly cause us to be still doubtful as to the ultimate result. On the other hand, *I have seen* cases similar to that we are considering, in which unfavourable symptoms occurred from which recovery was absolutely impossible; such cases are undoubtedly frequently fatal. We may conclude, therefore, duly considering these facts, that our patient, if he survives this immediate illness, and is not attacked by a fatal relapse, may live to end his days by some other affection."

Cultivate this method, and a reputation may be acquired that will last even to the end of a senior appointment. Then, the Hospital left behind, the student will discover how wisdom may be stultified by her children; how genius is great in spite of, not by reason of, its eccentricities, and that however his may impose on Maze Pond, it is not in the least likely to cheat the world.

L.

The Dangers of Douching.

THE Douche is now so widely employed after labour or miscarriage, that it is quite forgotten that there is an ever present danger connected with its use, of which the two following cases are examples. I have also lately heard of a case in a Northern hospital which had a fatal issue on the same day as the accident.

Mrs. B., æt. 30, a vigorous healthy woman, was safely delivered, at a normal confinement, of her fourth child, and all went well until the morning of the eighth day. At 10.30 a.m. I was suddenly summoned to see her. On my arrival, half-an-hour later, I found her in a state of rigor, very pale and collapsed, with cold extremities, and complaining of intense pain in the lower part of back and abdomen. Temperature 101 F.; pulse 90. On vaginal examination I found some bright blood in the canal, the cervix uteri patulous, and the internal os patent.

It appeared that the nurse proceeded to give her patient a douche, as had been her custom, consisting of a weak solution of Condy's fluid, and that immediately after the first squeeze of the ball of the syringe the patient had cried out with pain and fell back on the bed, then becoming so collapsed that she thought death was impending; a little bright blood flowed from the vagina. The patient vomited two or three times, and then passed into the condition I have described above.

At the end of half-an-hour the rigor had ceased; the face was flushed, and the pain passing away. Temperature 103; pulse 100.

2 p.m. Patient was recovering from the shock. The abdomen was distended, and tympanitic; there was no tenderness except over the uterus. Temperature 103·8; pulse 120.

9 p.m. Condition as at two o'clock. Temperature 102·2.

Next day the temperature was 100 F., and she returned to the normal condition in a day or two without an adverse symptom.

The second is a case, communicated to me by an old Guy's man, of which the following are the general outlines:—

A woman aborted, but abortion being incomplete, a douche of Perchloride of Mercury was ordered. Immediately after the use of the douche the patient was collapsed, then had a rigor and the temperature rose to 103, but rapidly fell again to normal. During the following week there was tenderness in the lower part of the abdomen, and in addition symptoms of acute mercurial poisoning ensued from ulcerative stomatitis, vomiting, and salivation. The patient made afterwards a good recovery.

There can, I think, be no doubt that fluid passed through the uterus and Fallopian tubes into the abdomen, in both cases, and caused the severe and alarming symptoms above narrated.

V. P.

The Fatal Accident on the Zinal Rothhorn.

BY DR. PETER HORROCKS.

It is now a long time ago since Mr. Leslie Stephen wrote that delightful book, "Switzerland as the Playground of Europe." At that time comparatively few visited the Alps, but a much larger proportion of them were mountaineers. The changes that have been wrought by the further development of railways enable many to visit the very heart of the Alps, and even to ascend some of the mountains, from the top of which magnificent views can be obtained.

The object of a mountaineer is not simply to obtain a view on reaching the top of any given peak. To the amateur climber who goes for pleasure, the purpose is to gain the health and strength which may be derived from the exertion required in climbing. He obtains pleasure from overcoming difficulties; when a particularly stiff piece of work presents itself, the reconnoitring, the trials by different ways, and the final success afford a pure pleasure that only those who have been touched by the Alpine fever can appreciate. It is astonishing how invigorating it is to undergo toil in the mountainous regions of Switzerland.

It has been said that no air is so bracing as that on a glacier; whether it is so or not, and what the explanation may be, is not known, but no holiday does one so much good as one spent in Alpine climbing. These few remarks I have made in anticipation of the *cui bono?* which many may ask after reading this article.

My holidays commenced at Chamonix. The Mer de Glace, Mauvais Pas, Flegère, Brevent, Glacier des Bossons, Pierre de la Pointue and the Jardin occupied about a week, and served to get oneself into training for more difficult work. An expedition over the Col du Géant was prevented by bad weather, and so in the snow and rain we walked over the Col de Balme and the Tête Noire. At Zermatt we practiced step-cutting on the Séracs of the Gorner Glacier. We climbed the Riffelhorn from the glacier. It is rather stiff rock climbing, and in one place, Biner, our guide, was unable to reach, so got on to my shoulder; he was very heavy—I should guess about thirteen stone.

When we reached the top, we were rewarded by seeing the sun set to the right of the Matterhorn, and the moon rise above Monte Rosa. We dined at the Riffelhaus, and descended to Zermatt by moonlight. After a few other climbs, we started for the Matterhorn, but a snow storm put an end to that expedition. We therefore decided to try the Zinal Rothhorn. My friends, Mr. and Mrs. Garrett, engaged two first-rate guides named Edward Julen and Emile Gentinetta, and I engaged two equally good guides named Josef Marie Biner, already mentioned, and Peter Perren. We walked up the steep and lonely Trift Valley to the Trift Inn, which is 8,000 feet above the sea level, where we had dinner about 5.30, and went to bed at 8. The guides were to call us at 2 o'clock. I was awake at that hour, and heard them moving about on the wooden floors with their heavily nailed boots. They had some conversation and then went to bed. I got up and on looking through the window saw that we were enveloped in clouds, and that it was raining; so obviously the expedition had been given up. At 7 a.m., when we breakfasted, it was fine, but we agreed to wait until the next day. In the meantime, we went to the top of the Mettelhorn (11,190 feet) and back, leaving the guides at the Inn.

Next morning we were called at a quarter to two, and after partaking of coffee, bread and butter and eggs, we started punctually at 2.30. The Trift Valley was in dark shadow, but there was a gibbous moon, and the stars seemed brighter and larger than usual. Hence we were able to proceed without lanterns. We kept close to one another's heels, and were soon ascending the huge moraine at the head of the valley. When we reached the glacier the ropes were put on. The day broke above the mountains on our right, and the delicate shades of colouring were more beautiful than any I have ever seen. The Matterhorn appeared at one time bathed in a rosy red, which the guides said meant bad weather in a few days' time. We noticed, also, that our shadows on the snow were a pale blue colour for several minutes. After ascending the glacier for some time we took to the rocks on our left and climbed an ice slope, which was in fairly good condition. After this we had more rock work and another ice slope, at the top of which we had to traverse an edge called an Arête. It was perpendicular on our right and very steep on our left, there being only just room for the foot, so that it was necessary to step exactly in the steps made by the leading man. This was perhaps the most difficult bit of this mountain and required a steady head. We crossed it in silence.

When we reached the place called the Gabel, Mr. and Mrs. Garrett and myself left our axes as it was chiefly rock work from that point. We climbed on, passing the place where the accident afterwards occurred, without thinking it dangerous compared with many other places. We ascended the first peak and then got on the saddle and up a very steep ice slope where step-cutting was again necessary. The particles of ice dropped into one's neck and acted like an ice shower-bath. We reached the top at 11.30 a.m., after a delightful climb of nine hours, having had something to eat every three hours. It was a perfect day, the hot sun shone gloriously and there was an almost cloudless sky. Only here and there amongst peaks, fifty to a hundred miles away, could be seen a few clouds fantastically arranged so as to suggest all sorts of pictures to the imagination. Showing the clearness of the day, we could not only see the whole range of the Bernese Oberland and the Mont Blanc group with the sharp Aiguilles in the Chamonix region, but also the mountains of the Engadine.

Milan Cathedral could be distinctly seen lying far away down the Italian valley. The Matterhorn appeared

to be close to us, and actually below us, although it is much higher (Matterhorn, 14,705 feet; Zinal Rothhorn, 13,855 feet). The guides were in high glee, and their *Jodel*, that is, the singing peculiar to Swiss mountaineers, had quite an exultant note in it. We opened half a bottle of champagne, and divided it amongst the whole party. Afterwards we slipped a card into the bottle with our names and the date written on it, and placed it at the top amongst others left by previous climbers. We stayed three-quarters of an hour, and commenced the descent at 12.15 noon. The steep ice-slope was rendered more hazardous to us because we had no axes, and so had to stand vertically in the steps in order not to slip. We descended in the same way, crossed the saddle of the mountain, passed over the lower peak, and descended this to the point where we had to cross the face of the rocks. The place is called the Plättje or Blätte. It overlooks the Durand Glacier and the Zinal Valley. The rocks are steep, but the place to traverse is not more than perhaps twelve feet wide, the ledge to walk along averaging four inches in width. Biner crossed first, and I paid out rope to him; having got to a safe place he turned round and drew in the rope. As I traversed the ledge with my face to the rocks, I could see both Biner and Perren. In order to understand the position it must be remembered that there were thirty feet of rope between Perren and me, and twenty-five between me and Biner; most of this, however, was held in coils in the hand of each guide.

Suddenly I saw Perren slip on his side, and almost the next moment I was jerked backwards with so much violence that the breath was audibly expelled from my thorax. As I fell headlong over the precipice, I had just one moment to realize that our fate was sealed, and then my head struck on the rocks, and I lost consciousness. On recovering, I found myself suspended, looking down on to the Durand Glacier over 2,000 feet below. Naturally I clutched at the rock, when I heard Perren shout, "Don't move, sir."

It then struck me that probably Biner was holding on to the rope and that he had saved the lives of Perren and myself, and that if I moved he might be unable to retain his hold, so I kept quite still. Perren was shouting for help. The blood began to drip from my head on to my coat, and so I felt my pulse. It was strong and at its usual rate, about 70 as far as I could guess, so I knew I had not lost a large quantity of blood.

Every moment I expected the other guides would come to Biner's assistance and that we should be rescued. After waiting about ten minutes, I felt it would be as well if I could secure a hold on to something, and so, in spite of Perren's remonstrances, I wriggled myself round so as to face the rocks, and then I found a projection which gave a good handhold. On looking down, I discovered another one which enabled me to rest the inner edge of my right foot. Looking up, I saw Gentinetta, and at once asked him "Where is Biner?" after a pause he replied "He is lost!" Gazing about me, I then perceived that the rope was broken and lay in a coil about the rock on which I was suspended. Perren was thirty feet below me, and was concealed from my view by a projection of the rocks. The rope between him and me was intact, and was wedged in a cleft formed between the top of one huge slab of rock and the face of the one above it. As this was close to me, I was able to examine the rope minutely to see that it was not cut or damaged in any way.

Gentinetta, the leading guide, on the next rope, was the only one who saw the accident completely. He was very much upset. It was necessary for them to traverse the narrow ledge in order to get to a place where they might unrope with safety. This they did, but owing to the nervousness of the guides it took a long time, and it was quite an hour before they rescued us.

After unroping they fixed the rope to a projecting rock, and let down the other end to me. I fastened this to my body, then jerked out the rope from the chink, and bound the broken end so as not to impede my movements. With the left hand I was able to pull up Perren sufficiently to allow him to get over the projecting piece of rock below. He found a handhold, and stopped whilst Gentinetta and Julen gave me similar assistance from above for a short distance. In this way, moving alternately bit by bit, we were both rescued from our perilous position, and the two guides were so delighted that they embraced us.* I learnt afterwards that Perren slipped because a stone against which he placed his foot suddenly gave way. In trying to save himself the coils of rope hanging on his right wrist slipped off, and the falling stone in some way caught these coils and pulled him over the precipice. He fell, of course, for 30 feet before I was jerked off, and poor Biner was dragged from his place when we had fallen another 25 feet. For 15 feet we must have all three fallen together, because Perren fell 70 feet altogether, and I fell 40 feet. The rope between Perren and myself caught in a chink, as already described, and stopped our further descent. Biner fell past me, and having fallen 65 feet (*i.e.* 40 feet to where I was, plus 25 feet, the length of rope between us), the sudden jerk on the rope caused it to snap, and poor Biner was precipitated on to the glacier 2,000 feet below, bounding over and over as he went. The rope snapped 16 feet from me and 9 feet from Biner. Naturally, Mr. and Mrs. Garrett and their two guides were extremely anxious to know if Perren and myself had escaped without serious injury, and they were very much relieved to find that this was the case. At the same time, the fall of the guide Biner was very saddening, and we all felt it keenly. My guides held a consultation and decided to fasten the two ropes together, for us all to descend on one rope. We did this, the guides taking extra precautions, and in consequence, we made slow progress. We picked up our axes in the Gabel, descended the rocks, crossed the Arête in silence but safely, and then found that the ice-slope was not safe,

*In the picture made by the *Daily Graphic* artist, he has put one too many in the rescue party, and the two guides embraced Perren and myself only after we were both in safety.

and so had to keep to the rocks. This took more time, and in spite of much effort night fell upon us before we had reached the glacier. We wanted to rest but the guides would not hear of it, and so in spite of great fatigue, we struggled on in the dark, until at last, the glacier was reached. Here we sat down on the ice and had some wine, but we could eat but little. The lanterns were lighted and these were seen from the Riffelhaus and the Riffelalp. We descended the glacier by candle-light, and reached the Moraine at last, where the rope was removed. In the middle of that wilderness of stones and débris, two women from the Trift Inn met us with a basket containing tea, wine, sandwiches, etc. It really was exceedingly good and kind of them to climb all that distance, but they knew we were very late and were also concerned because they saw but three lanterns whereas they had expected to see four. After enjoying what they had brought, particularly the tea which was very refreshing, we continued the descent which lasted another hour, although we went at a good speed.

We reached the Trift Inn at 10.30 p.m., having been away just 20 hours. The guides were too tired to go on to Zermatt. We were provided with a good dinner, late as it was, and I cannot speak too highly of the Trift Inn for comfort, cleanliness, cuisine, and the genuine kindness of those who keep it. My friends, Mr. and Mrs. Garrett, were also exceedingly kind, and did all they could to help me. But we were all very tired, and so we soon went to bed. Julen and Perren started quite early (4 a.m.) for Zermatt to give information of the accident. Twelve guides, forming a search party, were speedily sent off. We left the Trift Inn about 11 a.m. the next day, Gentinetta accompanying us to Zermatt. The search party stayed at the Trift Inn and started at 1 a.m. on Saturday morning. They had to ascend in the same way over the huge Moraine, but went over the Triftjoch in order to reach the Durand Glacier. They found the body of the poor guide about 11 a.m., lying on the Durand Glacier at the base of the Zinal Rothhorn. With the exception of a few shreds of his shirt still clinging round the shoulders, the body was quite naked and battered into pieces. The boots were found with a piece of skin attached. Near the body lay my hat, and some distance away the remainder of the rope was found. They took the body across the glacier to the Mountet Hut and thence to Zinal and Sierre. Here it was placed on a train and brought by rail to Visp. From Visp it was brought by road to Zermatt, arriving there on Sunday night. The funeral took place on Monday morning, and the remains were interred in a grave lying just below that of Michel Croz, who perished on the first ascent of the Matterhorn. The little Catholic Church was filled by the men and women of Zermatt, and there could be no doubt that Biner had been held in high esteem by his fellows.

Such is the plain narrative of the facts regarding this accident.

If the rope had not so fortunately caught, all three of us would have been dashed to pieces; the bump on my head was a friendly anæsthetic, and my hope is that poor Biner received a similar blow, rendering him unconscious, and so causing his death to be practically painless.

An official enquiry was held at Zermatt, at which I gave evidence. They had both ends of the rope on the table, and I examined it carefully. It was an English Alpine Club rope, with the red thread running through it. No weak spot was anywhere discoverable, and it seemed to be an excellent rope, and but little used. The broken ends were drawn out like a horse's tail. Some people have said that unless the rope had a weak spot, or unless it was damaged in the descent, it might not have broken. I do not think so myself. No Alpine Club rope whatsoever could stand the jerk of a weight like Biner's falling 65 feet. It is true the rocks are not vertical for 65 feet, but they were vertical for about 20 feet where I was hanging, and moreover Biner would probably be jerked forwards into the air, and so fall more or less sheer for most of the 65 feet.

Perren fell feet first and alighted on a ledge of rock covered with soft snow. In spite of a fall of 70 feet, he retained possession of his axe, and brought it up with him. He escaped with a few bruises on the left side of his chest. I received a scalp wound over the middle of the left parietal bone, some bruises on my left lower extremity, and a few cuts on the left hand. The glass face of my watch was broken, but the watch was going. My waistcoat was unbuttoned from top to bottom, and my coat and knickerbockers torn down the left side. My spectacles, which have ear-pieces, were uninjured, and whilst I was suspended I could see far away below me a huge eagle poised with out-spread wings.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

An Early Experiment in Transfusion Methods.

SIR,—The following historical reminiscence may be worthy of some interest. I came across it in "T. B.'s Analecta," published in 1693, and it is culled from a letter of Loenwenhoeck's of Delft, 1677:—

"Dr. Gräff open'd the Vein of a Dog, and let out so much Blood that the Dog grew faint; then he open'd the Artery of another Dog, and by a Pipe transfus'd the Blood of the second into the first; whereby the first recovered; the second was faint. Then the Dr. injected back into the Artery of the second a quantity of Cows Milk, supposing thereby to preserve the second Dog alive, saying, Milk was Blood; but no sooner was the Milk injected but the Dog died."

As cited, it shows up, in the language then in vogue, as an ingenious or inquisitive enquiry; and is an instance that Experimental practice has been the medical record of advance, down the long line of successors after Hypocrates.—Yours, etc., H. ELLIOT-BLAKE.

Passim.

THE first of the Annual Winter Smoking Concerts will be held to-night in the Club Smoking-room, at 8 o'clock. Mr. Slater, who will take the chair, has arranged an excellent programme in which the comic element, we understand, predominates. We can assure "freshmen" and junior men that the Smoking Concerts at Guy's always afford a pleasant evening's amusement, at the same time reminding them that early attendance only will secure them good seats.

TO-MORROW (Sunday) afternoon Miss Honnor Morten, Hon. Sec. Nurses' Co-operation, will lecture at the South Place Institute, Finsbury, E.C., on "Nursing." The lecture is free, and an organ recital will be given, followed by a vocal solo from 3.30 to 4 o'clock, when the lecture will commence.

WE are greatly indebted to Dr. Horrocks for the account of his thrilling experience in Switzerland. He wishes us to state the subscription list for Biner's widow and seven children is still open, and he will be happy to forward any donation that may be sent to him at 26, St. Thomas's Street, S.E.

AT the conclusion of his contribution, Dr. Horrocks says, "I take this opportunity of thanking all those who have so kindly sent me their congratulations on my escape."

WE have been asked to draw the attention of subscribers to the R. M. B. College to the case of Richard Greenhill Silverlock, aged 8 years, son of the late "Dick" Silverlock who was at Guy's during 1879–84. The case is strongly recommended for the May election by Dr. Savage, Dr. de Vaux Balbirnie, Dr. Colmer, J.P., Mr. Jago and Mr. Herbert Manley. Proxies will be thankfully received by Mrs. R. G. Silverlock, 153, Portnall Road, St. Peter's Park, W., and Dr. P. S. H. Colmer, South Street House, Yeovil.

THE Guy's Hospital Oxford and Cambridge Dinner will be held at St. James's Restaurant on November 27th, at 7.30, when Dr. Connolly has kindly consented to take the chair. It is hoped that there will be a goodly attendance.

WE are sorry to hear from the Secretaries of the Debating Society that, owing to indisposition, Sir Albert Rollit is unable at present to comply with their request to give an address before their House. He has, however, promised not to "forget the matter," and we may confidently look forward to an inspiring address from him when he is able to honour the Society.

WE are informed that the proposed subject for the next meeting of the Debating Society is to take the form of a motion in favour of the adoption of the Gothenburg System in this country. The matter is nevertheless in abeyance until an opposer is forthcoming. Any member willing to speak in opposition is requested to communicate with the Hon. Secretaries without delay.

IT has been our pleasure on more than one occasion to thank the lay Press for kindly assistance, and we are specially grateful to the proprietors of the *Daily Graphic* for the very generous way in which they have allowed us to reproduce the illustration made by their artist, and published as a supplement in our issue to-day.

WE are glad to hear that Jackson Lang, who, as many of our readers are aware has been suffering from typhoid fever, is now convalescent, and was allowed to leave Clinical in the middle of the present week for a change. We heartily endorse the universal wish, that he may soon return to full health and strength.

In our last issue we inadvertently omitted to include in the list of Theses presented to the Library that on "The Results of Tracheotomy in Diphtheria," sent by A. J. Collis, M.B.

Although that species of pilfering "bug," whom we may term the "hospital sneak," is still found to cultivate his filching and plundering tendencies to an alarming extent, until the very air becomes infected, yet no one appears capable of isolating him. The medium but lately selected was Clinical — the sacred haunts of light and leading; now, is there lamentation over two *well-worn* and beloved guides to knowledge in Medicine and a brand new equally necessary, instrument—a silk umbrella, and in this weather, too! which are "gone for evermore."

Seriously speaking, the man who is lucky enough to expose the unmitigated scamps whose ways of living are so detrimental to the *bonhomie* of our Club as well as of our Hospital, will be doing a service for which he could never be repaid in full.

In connection with an allied matter, we feel it our duty to publicly thank the President and Committee of the Students' Club for the very strenuous efforts they have made to put a stop to the disgraceful practice of some—alas! members, *not* Gentlemen—of our Club, in places so necessary to the well-being of the community. Mr. Durham's powerful words at the Annual General Meeting will, we trust, bear fruit.

We are, however, aware how futile often an appeal to the good sense of these "individuals" is, for the simple reason that they have none.

It is to the co-operation of all our other members that we must look then, if our Committee in its determination to uphold the best traditions of the Club, in which most of the hard work falls to their share, is to carry out its purpose effectually.

Residents in the College have of late been forcibly made aware of sundry blatant noises and discordant voices which, on consideration, somehow seemed familiar. They may rest assured that the steward's cellars have not become the abode of insanity by an order of the Local Government Board, but that the Christmas N——, but stop, we had almost given the whole bag of tricks away!

We have received from a correspondent a letter suggesting a scheme for adding to the funds of the Hospital a substantial sum annually, by appealing to old Guy's men. We think the idea an excellent one, and have had thoughts for some time of initiating such a scheme through the medium of our columns.

At present we are not in a position to definitely formulate a satisfactory plan. The details will, we hope, soon be settled, and should the idea catch on among old Guy's men, we are confident that, although the sum cannot from the nature of things be fabulous, yet many will be allowed the privilege of helping their old Hospital towards a brighter financial issue.

The Association Football Club are to be heartily congratulated on their splendid performances since the season commenced. With the exception of one Second XI. match, all have been won by substantial majorities. We hope that the unfortunate accident to Lidderdale, which, it is feared, will keep him out of the field for some time, will not break the line of success.

We heard the other day of a dresser, not 100 miles from London, who, in a fit of absent-mindedness, was observed to stuff a piece of lint with which he had been cleaning a Saturday night wound into the pocket of his dressing coat, and then to throw his forceps into the pail, *not* "provided for that purpose." A fact!

The Fatal Accident on the Zinal Rothhorn.

(1). Dr. Horrocks crossing the ledge. Perren on the left, Biner on the right.

(2). The fall down the precipice. Perren lowest, Dr. Horrocks in the middle, and Biner above.

(3). Dr. Horrocks suspended by the rope, which has caught in a cleft, and which passes down to Perren, who is standing in soft snow on a narrow ridge of rock.

(4). Gentinetta is near the rock round which the rope is twisted. Julen is assisting Perren. The two figures embracing is a mistake of the artist. *Vide* the foot-note p. 415.

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A Case of Snake Poisoning.

By SURGEON-CAPTAIN S. E. PRALL, M.B. Lond.
(Communicated by Dr. Pye-Smith).

K. M., æt. 30, a Hindoo beggar, was admitted into the Bijapur Hospital, Deccan, on August 23rd, having been bitten by a snake one hour previous to admission at 11 a.m.

On admission.—The patient was slightly hemiplegic on the right side and appeared half-witted. There was a cobra, still living, grasped between the thumb and index-finger of the left hand. Both hands appeared somewhat swollen up to the wrist-joints. There was a mark of discolouration over the terminal joint on the extensor surface of the right thumb, and two minute marks of the poison-fangs were visible in this situation when seen through a magnifying glass. There were also two blood-stains close to this part on the thumb, as well as one stain over the left index-finger. Patient was somewhat drowsy, but was able to answer questions.

The cobra was removed from his hand with difficulty and killed; it measured 15¾ inches.

After half-an-hour's close observation, patient became more drowsy, and was unable to keep himself in a sitting posture. There was discharge of thick saliva from the mouth and mucus from the nose. Skin somewhat cold. Pulse 112; small. Breathing, somewhat hurried. Patient ate about a dozen red chillies without complaining of burning in the mouth. Liq. Strychninæ ɱxv. were injected hypodermically. An hour later (12.30 p.m.) injection of strychnine was repeated. Skin colder. Pulse 100. Drowsiness continued, and also expectoration of thick mucus from mouth. Patient occasionally answered indistinctly when called by name.

At 1.30 p.m., injection of strychnine was repeated, and mustard poultices were applied over the chest and epigastrium. There was slight difficulty in swallowing; breathing more hurried; foaming at lips. Pulse 96.

At 3.45 p.m., surface and extremities were cold; both hands swollen. Thick fluid in throat, with difficulty of expectoration. Knee-jerks exaggerated on both sides; more so on right. Pulse 104. Heart-sounds regular, but faintly audible. Patient semi-conscious. Can be roused by shouting, answering intelligibly. Pupils equal and apparently normal. Strychnine injection repeated in præcordial region.

Between 3.50 and 4 p.m. patient had six spasms of body and extremities; the last accompanied with shallow respirations, which were abdominal.

Spasms continued—sometimes violent—of the whole body, or of legs alone, at short intervals. Pulse 76; regular, soft, compressible. Expectoration of tenacious mucus and saliva almost continuous.

At 4.35 p.m., spasm excited on touching patient. Salivation not so marked. Temperature 97·8. Spasms decreased in frequency and violence. Respirations averaged 20. Pulse 80, until, at 6.30 p.m., patient was found to be warmer, and the spasms ceased. Warm lead and opium lotion was applied to the hands. Pulse 82, and full. Salivation ceased at 7 p.m. An hour after, respiration was natural, and no spasm could be excited when any part of the body was touched.

At 10 p.m., twichings had ceased for three hours, and patient was much more conscious. At 11 p.m. he was quiet and easy, and was able to take some milk. Complained of pain in both hands.

August 24th. Patient slept during the latter part of the previous night. At 7 a.m. he was quite conscious. Swelling in hands had diminished, and there was only pain in the left thumb.

25th. Patient recovered.

The hemiplegia noted was of old date.

The snake that caused such severe symptoms was a very small specimen: the cobra commonly measures four or five and sometimes six feet in length, but this last measurement is rare. The treatment by strychnine, commenced by my assistant in my absence, should have been repeated every fifteen minutes, till the physiological effect of the drug was produced. However, it was repeated thrice, at hour intervals, before my arrival; and the last injection (the fourth), given by me, produced spasms in a few minutes, and the physiological effect being once established, the patient recovered rapidly. Giving the patient chillies to eat, and noticing his behaviour on chewing them, is a native test of the degree to which the poisoning has proceeded. Neelun leaves, which are as inordinately bitter as the chillies are pungent, are used for the same purpose. The other points noticeable, and peculiar almost to cobra-poisoning, are the intense salivation and the acute general depression of all the nervous powers.

Some Cases treated with Sulphur.

The following cases, treated by Mr. Lane, illustrate the great value of Sulphur as an external application, and the varied conditions in which it may be of use. In the majority of cases, the time test has still to be applied, in lupus, for example, being the only one of any value; but in the more chronic tubercular cases with intractable sinuses, associated with a general depreciation of vitality, expressed as debility, anæmia, emaciation, or even failing mental powers, the immense improvement, both local and general, which will take place during even a few weeks' residence in the hospital, affords a very sufficient proof of a far-reaching action, and seems to suggest that by the absorption of some of its products at the site of application a powerful antidote to the tubercular toxins may be circulated in the body. At any rate, there can be no question as to the thorough nature of its work as a local caustic. Under favourable conditions as to warmth and moisture, twenty-four hours amply suffices for one application, the process, except in the case of delicate mucous membranes, being also painless, and accompanied, as a rule, by a rise of temperature, which serves as a

useful indicator of its efficiency, though this cannot be relied upon. Gauze, soaked in a mixture of precipitated sulphur and glycerine, and sterilized, may be packed into tubercular joints and sinuses; in a more liquid form, the mixture may be syringed into passages, such as the urethra; or as a paste, rubbed into a scraped lupoid ulcer.

The cases represent only a few of those treated, and some may have previously appeared in the GAZETTE. The impression made by a series of similar cases as compared with isolated examples appearing at considerable intervals, must be my apology for republication. The merest outlines only are given.

CASE 1.—E. P., æt. 40. Admitted 27th September, 1894, into Patience for carbuncle of shoulder, of three weeks' standing, the size of five-shilling piece, with some amount of cellulitis and induration round about. Opened, scraped and packed with sulphur, and made a rapid recovery.

CASE 2.—R. M., æt. 44. Admitted 2nd August, 1894, into Lazarus for an old traumatic stricture and very foul urine. Pyuria soon after admission, and steadily increased, with great pain at the end of micturition. On September 21st bladder-walls were found ulcerated. Sulphur and Glycerine injected September 26th, causing a temperature of 104·2. Four days later, the injection was repeated (the diagnosis being tubercular bladder), with the same result. The patient distinctly asserted that his pain was relieved after the use of the sulphur, but the good done was practically nil, the whole genito-urinary tract proving to be infected. The case merely shows the possible utility of sulphur in early tubercular disease of the bladder.

CASE 3.—E. G., æt. 18. Admitted October 4th, 1894, into Dorcas for lupus of nose, which had been scraped five times during the last three years. Nose was well scraped and precipitated sulphur applied under a hot compress. When last seen, October 15th, the surface had healed and appeared quite healthy.

CASE 4.—A. S., æt. 14. Admitted into Lydia September 8th, 1894, having been confined to bed for a year with a fistula in ano. Very emaciated and anæmic. Examination under an anæsthetic showed two fistulæ, one opening into the rectum, and a second passing up beside the bowel for six inches, with bare, rough bone at the end of it. Considerable ulceration of skin around the anus, and absolute incontinence of fæces. Both sinuses well scraped out (the smaller being also slit up), and packed with gauze and sulphur, the process being repeated at least once a week. Control was regained in the fourth week, and the patient very rapidly gained in weight, colour and animal spirits, leaving the Hospital cured on October 21st.

CASE 5.—J. A., giving his age as 28, in appearance about 40. Admitted into Job September 4th, 1894, with a very old dorsal dislocation of the left hip, in which suppuration had recommenced ten weeks ago. Pronounced anæmia and wasting, with a tendency to hysteria from loss of mental control. The thigh fixed at an angle of 45, marked lordosis, entire absence of joint mobility, wasting and shortening of the limb. Evening temperatures of 102—103.

September 7th.—Mr. Lane made a fresh joint beneath the anterior inferior spine, fixing the head of the femur in that position with much trouble. The old diseased joint was scraped out and packed with sulphur, which has been frequently re-applied three or four times a week. The patient has improved rapidly, his limb is straight; the sinuses have almost ceased to discharge; the evening temperatures rarely reach 100; the nervous prostration has disappeared; he has gained steadily in weight and colour, and will shortly be leaving the Hospital.

CASE 6.—E. W., æt. 36. Admitted into Job 4th September, 1894, for extensive tubercular ulceration of the prostate and perinæum, opening into the rectum, and into the perinæum by several sinuses, of twelve years' duration. On admission, he had albuminuria, frequent rigors, much pain—especially at night—and general induration of the perinæum. Evening temperatures of 102. General emaciation very marked. He was at once treated by scraping and injections of Sulphur and Glycerine; the first injection causing a temperature of 106 and a severe rigor. The injections were repeated every other day, and later on, every day. He left the Hospital on September 27th, to continue the treatment for himself at home. At present he comes up daily, and has sulphur injected in the ward. Sufficient time has not yet elapsed for complete recovery, but in every single detail he has made, and continues to make, steady improvement. In this case, as in the last, the change in general health being the most marked.

CASE 7.—A. B., æt. 40. Admitted into Accident for a wound across the dorsum of the foot, not dividing the vessels or tendons, but very dirty. The man had been a hard drinker. The wound was cleaned under an anæsthetic and cyanide dressing used. Forty-eight hours later early signs of gangrene appeared, and hot Carbolic 1 in 40 was put on. The gangrene rapidly spread, and in twenty-four hours the whole foot was boggy and angry-looking; the skin over the four smaller toes black, shading into purple down the dorsum and sole. Sulphur was at once applied, and a hot compress put on outside it. Almost immediately the symptoms began to subside. The sulphur was renewed every four hours, and the man ultimately escaped with the loss of four toes only; whereas, a few days previously, it only appeared to be a question of how high up the leg to amputate.

CASE 8.—E. T., æt. 21. Admitted into Dorcas October 12th, 1894, for extensive pulpy disease of knee. Excision was performed, and the operation showed it to be almost impossible to remove all the diseased parts. The joint was accordingly packed with gauze saturated with sulphur and glycerine, this being removed twenty-four hours later under an anæsthetic; the temperature rose to 103, reaching 98·4 in a week's time, where it has since remained.

CASE 9.—M. G., æt. 4. Admitted into Dorcas October 12th, 1894, for spinal caries with extensive abscess in

back. On the following day the abscess was opened and the cavity plugged with gauze and sulphur for twenty-four hours. The child's temperature has only twice risen to 99 since admission. The abscess cavity has practically closed.

CASE 10.—G. P., æt. 2. Admitted into Charity October 15th, 1894, for acute suppurative arthritis of shoulder, starting from a blow three weeks back. The joint was at once opened, a large quantity of foul pus escaping, and a considerable portion of the humerus was found bare. The joint and wound was thoroughly packed with gauze and sulphur, and the child has progressed well.

G. LAWRENCE.

Abnormalities in Dissecting Room.

OCTOBER AND NOVEMBER, 1894.

1. A "vas abberrans" arising from the outer and posterior part of brachial artery, about midway between superior and inferior profunda, in common with a muscular branch to the biceps muscle. The artery then gradually turns inwards, lying superficial to the brachial artery and median nerve. At the elbow it crosses in front of the superficial to the median basilic vein. It then lies upon the supinator longus immediately below the skin, gets to the radial side of the pisiform bone and anastomoses with the superficialis volæ to form the superficial palmar arch. The artery is of large size, having about the same diameter as the anterior tibial. The brachial divides at the usual place giving off the radial and a short thick trunk, which might fairly well be called the common interosseous, for after about an inch in length it divides into anterior and posterior interosseous and ends by giving a muscular branch to the flexor profundus digitorum immediately after. The interosseous arteries are abnormally large; the normal ulnar is entirely absent.

2. An additional palmaris longus. A well-developed spindle-shaped muscle was found arising by a somewhat expanded tendon from the lower part of the oblique line on the radius, between the radial origin of the flexor sublimis digitorum and the longus pollicis. The fibres soon converged to form a rounded tendon which expanded into a large muscular belt lying obliquely across the lower part of the forearm deep to the flexor carpi radialis, the palmaris longus and upon the flexor sublimis and median nerve, where it again became formed into a rounded tendon, lying on the inner side of the median nerve, and together with that structure passing deep to the annular ligament to become inserted into the palmar fascia on its deep surface about the middle of the palm of the hand.

3. Two well-developed sternalis recti on either side of the thorax, arising by tendinous fibres from the costal cartilages of the sixth, seventh, and eighth ribs, and aponeurosis of external oblique, and passing obliquely upwards and inwards to be again inserted by tendinous fibre into the upper part of the anterior surface of the gladiolus and the adjacent part of the lower portion of the manubrium.

In the rectus femoris muscle of the right leg on the same body, was a distinctly ossified portion of its tendon. The piece of bone fusiform in shape, in length about three inches and about one inch in breadth at its widest part, was situated in the upper part of the muscle on its deep surface.

4. The middle cervical ganglion of the sympathetic nerves is usually described in books as being directly upon the inferior thyroid artery, but out of ten bodies examined this session only once have I found that to be correct, the ganglion as a rule lying higher up in the neck, varying from a point immediately above the artery to two or three inches higher in the neck. Twice I have seen the sympathetic deep to the artery and in both cases the ganglia were higher placed than the artery. In these cases the superior and middle cardiac branches of the sympathetic passed in front of the artery.

J. O. GARLAND.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

J. S. S., TAVISTOCK.—The curetted mass possesses the structure of a spheroidal-celled carcinoma.

A. D. H., FARRINGDON.—Early epithelioma of the lip. The section showed that all the apparent growth had been excised.

G. F. H., BALHAM.—Tubercle bacilli present.

W. E. A., WELLINGBOROUGH.—Tubercle bacilli present.

A., TUNBRIDGE WELLS.—No tubercle bacilli were found in specimen.

J. E., MIDDLESBOROUGH.—Tubercle bacilli present.

W. L. W. M., HUDDERSFIELD.—Tubercle bacilli present.

A., TUNBRIDGE WELLS.—The cerebral growth is a spindle-celled sarcoma. There is no degeneration, but considerable infiltration of the brain substance.

M., SWAFFHAM.—The infiltrating mass is epitheliomatous.

M., MANCHESTER.—The mastoid growth consists of caseous tissue, and shows giant cells, and other results of chronic inflammation. It is, therefore, probably tuberculous in nature, though no tubercle bacilli or typical tubercles were observed. PATHOLOGIST.

Causes of Death in the City of London for the Year 1665.

Abortives, Still-born	617	Imposthume	227
Aged	1,545	Killed by Accidents ...	46
Ague and Fever	5,257	King's Evil	86
Apoplexy & Suddenly	116	Leprosy	2
Bedrid	10	Lethargy	14
Blasted	5	Livergrown	20
Bleeding	16	Megrims & Headache	12
Bloody Flux	185	Measles	7
Burnt and Scalded ...	8	Murdered	9
Calenture	3	Overlaid and Starved	45
Cancer, Gangrene and Fistula	56	Palsy	30
Canker and Thrush ...	111	Plague ...	68,596
Childbed	625	Planet	6
Chrisomes & Infants	1,258	Plurisy	15
Cold and Cough ...	68	Poisoned	1
Colic and Wind ...	134	Quinsy	35
Consumption and Tissich ...	4,808	Rickets	557
Convulsunt Mother	2,036	Rising of the Lights	397
Distracted	5	Rupture	34
Dropsy & Tympany	1,478	Scurvy	105
Drowned	50	Shingles & Swine Pox	2
Executed	21	Sores, Ulcers, Broken and Bruised Limbs	82
Flox and Small Pox...	655	Spleen...	14
Found Dead	20	Spotted Fever and Purples ...	1,929
French-pox	86	Stopping of Stomach	332
Frighted	23	Stone and Strangury	98
Gout and Sciatica ...	27	Surfeit ...	1,251
Grief	46	Teeth and Worms	2,614
Griping in Guts	1,288	Vomiting	51
Suicide	7	Wen	1
Headmouldshot ...	14	Total	97,306
Jaundies	110		

In 1664 the total deaths were only 18,297, including 6 from the Plague.

In 1666, the year of the Great Fire, the deaths were 12,738, including 1,998 from the Plague.

In 1667-8-9 the deaths from plague were, 35, 14, and 3; while in 1670 no death from plague was recorded. A few stray cases were observed for the next few years, but about 1678 the disease disappeared. Some of the causes of death are puzzling. Blasted may be translated lightning, but how about headmouldshot, imposthume, and planet, and rising of the lights, swine-pox, flux, and chrisomes and infants? Perhaps some of your readers may enlighten us.

In 1684 diabetes was notified for the first time.

Leprosy never seems to have been prevalent, although one or two cases occurred almost every year.

Small-pox varied a great deal; in 1663 the deaths from flox and small-pox were 411, while in 1729, 2,849 deaths occurred from small-pox—flox having disappeared from the nomenclature.

The name French-pox, for syphilis, can hardly be considered a compliment to our neighbours.

One thousand two hundred and fifty-one deaths from surfeit seems excessive when one considers the absence of medical teaching in those days, and remembers that Guy's was not in existence till 1724. Our ancestors were good physicians, although the Registrar of to-day would hardly accept grief, or planet, as sufficient cause for death.

S. G. FLOYD.

Guy's Hospital Students' Club.

Statement of Receipts and Disbursements from September 1st, 1893, to August 31st, 1894.

1893.—Sept 1st. RECEIPTS.	£ s. d.	£ s. d.
To cash balance at Bankers	6 4 7	
„ Balance of petty cash in hand	1 6 7	
		7 11 2
„ Subscriptions received from Subscribers to Students' Club—old arrangement ...		15 10 0
„ Cash received per Clubs' Union Account. Grant		75 0 0
„ Cash received per Clubs' Union Account. Rent		120 13 7
„ Cash per Library Account		33 7 5
„ Sale of Wine, Beer and Tobacco		707 10 4
„ Balance due to Bankers		57 13 0
		£1017 5 6

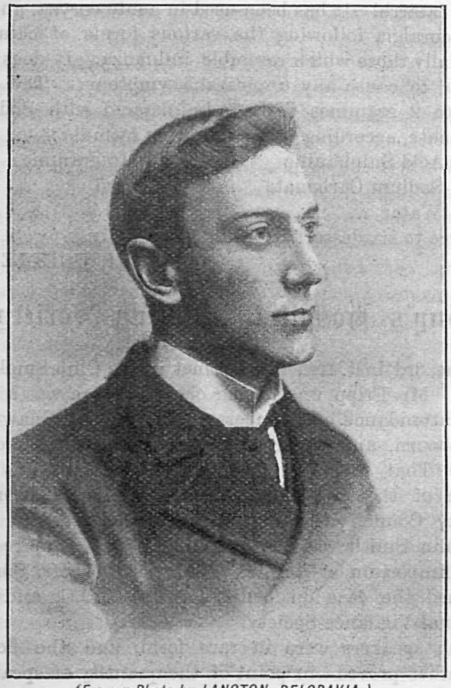
DISBURSEMENTS.		£ s. d.
By cash paid—Furniture Account		40 9 2
„ „ Newspapers and Magazines ...	£44 0 4	
„ „ Printing and Stationery ...	14 10 3	
„ „ Sundry Disbursements	12 0 4	
		70 10 11
„ „ On Gymnasium Account—		
*Hon. Secretary ...	24 0 0	
Cleaning & Lighting	7 6 9	
		31 6 9
„ „ Library Account—		
Mudies' Subscription	5 5 0	
Librarian	12 0 0	
Deposits returned	8 8 0	
		25 13 0
„ „ Rent Account		128 8 7
„ „ General Repairs...		13 0 3
„ „ Cost of Wine, Beer, &c.		450 7 7
„ „ Stewards' Allowances		257 2 9
„ „ Balance in hand		0 6 6
		£1017 5 6

Audited and found correct, on behalf of the Clubs' Union, FRANCIS J. STEWARD.

Audited and found correct, on behalf of the Students' Club, J. H. BRYANT.

*Balance in hands of Hon. Secretary, £7 1s. 0d.

Obituary.



(From a Photo by LANGTON, BELGRAVIA.)

FRANK WILHELM GOLDIE.

It is with very great regret and much sorrow that we have to record the death of Frank W. Goldie, one of our students, liked and loved by all who knew him. He was a man of exceptional promise and one of the few who gained a First Division at the last Intermediate London M.B. Examination. After this he went to Switzerland for a holiday, and from thence on to Venice. Here he seems to have contracted typhoid fever, which began to show itself about September 23rd. He had a mild attack, but this was followed by a very serious relapse, the most marked symptoms of which were delirium, lasting quite ten days, and a very high temperature, which necessitated frequent sponging and between twenty and thirty baths. He was recovering from his relapse, his delirium had ceased, and his temperature was ranging about 100 and 101, when, on November 1st, while straining at stool, he suddenly became livid and almost pulseless; he rallied from this, and when seen he was found to have a pneumo-thorax on the left side. It was known that for some two or three weeks he had a little fluid at that base, and therefore to relieve the breathing as much as possible it was aspirated; only seven ounces of turbid serum were withdrawn, but the operation rendered the breathing more easy. An attempt on the next day to draw off some air from the pleural cavity proved unsuccessful. On the afternoon of November 3rd he was doing as well as could be expected, but soon after midnight the circulation began to fail, and he died at 2.35 a.m. on November 4th. The sequence of events seems to have been that the pleurisy on the left side had rendered the pleura rather rotten, and during the act of straining it ruptured.

The old Greek saying, "Whom the Gods love, die young," may fitly be allowed to give expression to the feelings of Frank Goldie's friends. He was educated at Tonbridge School, where he soon earned a reputation for grit and steady work. On leaving school he went to University College, passed the London Matriculation and Preliminary Scientific, and came to Guy's in 1892, obtaining the second place in the Entrance Scholarship in Science. He passed the First and Second Colleges, and, as already mentioned, in the Intermediate M.B. gained a First Division in the Pass Examination. In hospital athletics Goldie did not take a very high place, with the exception of tennis, in which branch he was frequently one of the Hospital representatives, but he took the keenest interest in all hospital sport and work. By all those who knew him he was esteemed and beloved as a true friend and a thoroughly good fellow, and his untimely death deprives us of a clever and earnest student; one who maintained the best traditions and belonged to the best type of the "Guy's man." To his family we would express our sincere sympathy, and Mrs. Goldie wishes to convey through our columns her deep appreciation of the sympathetic messages which have reached her from so many quarters.

THOMAS STILES, L.S.A., M.R.C.S.

The death of Mr. Thomas Stiles, announced in our last issue, occurred on the 27th ult., at Spalding. The deceased gentleman was born on Easter Day, 1798. After apprenticeship with a surgeon at Wisbech he removed to London, studied at Guy's and St. Thomas's Hospitals, and was probably the last survivor of those who attended the lectures of Sir Astley Cooper, Cline, Clutterbuck, and Denman. In these early days he made two voyages to Greenland in the capacity of ship's medical officer, witnessing aspects of nature unfamiliar to the ordinary traveller and laying up reminiscences of adventure and hardship. Having qualified as L.S.A. in 1821, he settled down to the practice of his profession in the village of Pinchbeck, near Spalding, in which parish and the neighbourhood he was for more than forty years the best known, most useful, and most highly reputed resident. On retiring from practice some years ago he quitted Pinchbeck and made his home at Spalding, where the closing stage of his long and valuable life was passed in happy and honourable repose. Everybody knew the nonagenarian medical man; he had a kindly word for all, and no one will entertain other than pleasant and tender thoughts of him who is now no more. Up to the very last he had the clearest possible recollection of notable events occurring during his boyhood—the victories and death of Lord Nelson, for instance.—(From the *Lancet*.)

Notes from the Dispensary.

THE THERAPEUTIC USES OF IODIC ACID AND SODIUM IODATE.

IT has always been considered that the presence of Iodate in Potassium and Sodium Iodides rendered these salts unsuitable for internal administration. The British Pharmacopœia guards against this impurity by giving a special test for its recognition. It would appear, however, from the researches of J. Ruhemann (*Pharm. Zeitung*, No. 33, p. 292, 1894), that Iodic Acid possesses valuable medicinal properties with which it has not hitherto been credited. Iodate of Sodium has been employed with great success in the treatment of ulcerations, nasal catarrh, etc. In affections of the eye it has been used mixed with boric acid, and also in aqueous solution of a strength of 1 in 10.

Administered by the mouth it exercises a most favourable influence upon scrofulous affections. The subcutaneous injection of Sodium Iodate is of great utility for the resolution of ganglions. There is no danger in these injections, and it can be given up to 15 grammes during the whole treatment. The best mode of administration internally is in the form of pill, each containing 0·15 gramme.

Iodic Acid in a 5 per cent. aqueous solution is possessed of hemostatic properties. Fused and cast into sticks it is a caustic (*crayons caustiques*).

In obstinate vomiting Iodic Acid is extremely useful; its action in this case is attributed to the iodine which is liberated, and which gives it hemostatic properties.

SALANTOL.

When Bouchard introduced Beta-Napthol a special impetus was given to the therapeutics of intestinal antiseptics. Beta-Napthol is a powerful antiseptic, and at the same time non-poisonous, owing to its insolubility. Its allies, such as Carbolic Acid, Sulphocarbolates, Aceptol, Creasote with its derivatives Guaiacol, Iodoform, Chlorine, Resorcin, Thymol, Boric Acid and Benzoates, are useful in special cases, but they labour under the disadvantage of being poisonous or of being too soluble. Salol is the intestinal antiseptic at present in demand for the treatment of the so-called duodenal indigestion. This substance passes through the stomach unchanged, but in the small intestine is split up into Carbolic Acid and Salicylic Acid.

Salantol is the latest addition to the list of intestinal antiseptics. It is composed of Salicylic Acid and Acetone, and possesses the same action as Salol. Salantol is unaffected by the gastric juice, but is decomposed in the intestines into Salicylic Acid and Acetone. This remedy has been employed in the treatment of diarrhœa (*L'Union Pharmaceutique*, October, 1894).

SULPHANILIC ACID.

This acid figures in Guy's Pharmacopœia in the preparation of Ehrlich's test for use in enteric fever. I am not aware that it has ever been credited with any medicinal properties. In *L'Union Pharmaceutique*, September, 1894, is given an account by M. Valentine of his researches upon the therapeutic properties of Sulphanilic Acid. It appears that this substance acts very favourably and rapidly upon certain symptoms of acute catarrh. It has been used in acute coryza, and in the neuralgia following the various forms of catarrh, especially those which resemble influenza. It does not appear to cause any unpleasant symptoms. The dose is 1 to 2 grammes daily, administered with Sodium Carbonate, according to the following formula:—

Acid Sulphanilic	...	...	10 grammes.
Sodium Carbonate	...	...	8·5 „
Water ...	...	...	200 „

Three to six dessertspoonfuls given daily.

H. COLLIER.

Guy's Hospital Debating Society.

ON the 3rd inst. this Society met in the Club Smoking-room. Mr. Fripp was in the chair. There was a very large attendance of members, including Drs. Shaw and Washbourn, and the room was packed. The motion was, "That this House emphatically condemns the action of the Licensing Committee of the London County Council with regard to Music Halls." Mr. Hamblin Smith was the champion of the Empire and the "Imperium et libertas" party, while Mr. Spriggs watched the case on behalf of the L.C.C. and the National Vigilance Society.

Both speakers were in rare form, and the debate altogether proved—in point of the quantity of speakers, in the quality of the speeches, in the big division, and the enthusiasm of the audience—to be amongst the most enjoyable and successful debates in the history of the Society. Both Mr. Hamblin Smith and his opposer, Mr. Spriggs, are to be especially complimented on their oratorical performances.

Mr. HAMBLIN SMITH, in opening his case, traced the anti-music-hall movement, and the grounds upon which the L.C.C. might reasonably interfere with music-halls. He defended the morality of the entertainment and the behaviour of the audience. It was not so much a fight for a promenade as for a principle.

Mr. E. IVEN SPRIGGS defended the action taken by the L.C.C. He could not see why the abolition of drinks in the auditorium, or the doing away with the promenade, should lessen the excellence of the performance, or interfere with the comfort of the audience. He was quite of the opinion that music-hall entertainments satisfied a natural want of the great majority of the public, and could not find anything indecent in the "Living Pictures," but thought the promenade was a mart for vice, and ought to be abolished. As for the drink, Mr. Spriggs had very little sympathy with those who sold or drank it.

The usual painful interval followed before the next speaker arose, and we longed for someone less modest than ourselves to get up and propose that drinks—meaning thereby the coffee provided—should be served amongst the auditorium during the wait.

Mr. HAYWARD at last broke the spell, for, jumping to his feet, his sleeve he pulled up and his cuff he pulled down, and on the latter article of attire he had recorded his opinion that the promenade was the place to meet one's friends, and he repudiated Mr. Spriggs' notion that its use was reserved to the vicious.

Mr. MOFFATT pointed out that the contention of the last speaker was contradicted by the statements of the manager of the Empire.

Mr. A. M. RYGATE said that the opener of the debate had sneered at such a song as "Up I came with my little lot." It was, however, a very good song, and he reminded the House that the comedian whose name was associated with the ditty had maintained that the best friend of the music-hall artistes was Mr. McDougall, and that his party had done much to purify music-hall entertainments.

Surgeon BETT, R.N., was surprised to find so many at the debate on the re-opening night of the Empire. The L.C.C. doubtless acted in good faith, but right motive in such cases is not enough. He believed the promenade was largely used for perfectly innocent assignations, and described it as an excellent place in which to meet old chums.

Mr. HAM said "the Decline and Fall" of the British Empire would doubtless be more familiar to the coming youth than that "Decline and Fall" of a more ancient Power. There was a class of people who seemed to have the moral microscope ever glued to their eyes, in order to see the bacillus of putrefaction in the "scum" of society. He spoke in sarcastic terms of the so-called Purity party, and he scored heavily by his epigram on their creed, which he termed "a diarrhœa of cant and a constipation of charity."

Mr. RICE referred to the reported conference between the Licensing Committee and several of the critics of the Empire, when some of the agitators came from Liverpool. Charity began at home—let them first purify Liverpool.

Mr. PASSMORE said that Mr. Geo. Edwardes was now "hoist with his own petard." He strongly opposed the promenade, and the Empire to reserve for itself a "monopoly of vice."

"Then, changing to a softer note,
He spoke of subjects less remote—
He blew his nose, he cleared his throat,
Tears in his eyelids shone:
Of home—how happy it should be,
How doomed to endless misery,
When Angelina finds the key
To Edwin's goings on."

Messrs. Higgens, Glover, R. F. Clarke, Brickdale, Whicher, Pakes, Spon, and several other gentlemen, also contributed to the debate, but space will not permit of a report of their speeches.

A division was taken, when there voted:—

Ayes	50
Noes	22
Majority for Ayes ...	28

Examination Papers.

UNIVERSITY OF DURHAM FACULTY OF MEDICINE.

FINAL EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE, SEPTEMBER, 1894.

PAPER NO. 1.

Principles and Practice of Medicine.—1. (*a*) State fully your treatment for a young adult suffering from Typhoid Fever. (*b*) Enumerate the chief complications and sequelæ which may arise, and state how you would deal with them. 2. Define the following terms, and mention the principal diseases in which the physical conditions designated would be found:—Bronchial breathing, Bronchophony, Pectoriloquy, Laryngismus stridulus, Cheyne-Stokes' breathing. 3. What are the chief varieties of Uræmic Coma, and what treatment would you adopt, giving the doses you would employ? 4. Discuss the etiology, and give the symptoms of Locomotor Ataxy. Diagnose Locomotor Ataxy from Hereditary Ataxy, and from Ataxic Paraplegia. Give the treatment of Locomotor Ataxy. 5. Describe the symptoms of Ulcerative Endocarditis, and state what are the consequences that may arise in the course of the disease. Give the treatment of the condition. 6. Describe the etiology and symptoms of Rickets. Mention the chest complications that may arise, and explain how life may be endangered by them. Give the treatment of Rickets.

PAPER NO. 2.

Principles and Practice of Surgery.—1. Describe the more common fractures of the lower jaw, including their complications and treatment. 2. Mention the chief causes of acute suppuration of the knee-joint, and give the treatment you would adopt in each case. 3. Give, in order, the various structures which must be divided in an amputation at the wrist-joint. 4. State the courses, the common morbid results, and treatment of so-called Perityphlitis. 5. To what morbid changes are Bursæ liable? Name those most commonly affected, and give the treatment of each morbid condition. 6. What injuries or diseases render enucleation of the eyeball necessary? Describe the operation.

PAPER NO. 3.

Medical Jurisprudence and Public Health.—1. What is Infanticide? 2. Describe the symptoms of a typical case of General Paralysis of the Insane. 3. In what cases of death should an inquest be held? 4. What are the symptoms during life and the signs after death of phosphorus poisoning? 5. State what you know respecting the origin, mode of spread of infection, and prevention, of Diphtheria. 6. Give an outline of The Housing of the Working Classes Act, 1890.

PAPER NO. 4.

Midwifery and Diseases of Women and Children, and Pathology.—1. What causes may prevent forward rotation of the Occiput during labour in an Occipito-Posterior Presentation? What treatment would you adopt in a

case thus complicated? 2. What causes may give rise to Post-partum Hæmorrhage immediately after the expulsion of the placenta? How would you treat such a case? 3. What are the symptoms of Rupture of the Uterus during labour? What treatment would you adopt—(1st) If the child is still in utero? (2nd) If the child has partially or wholly escaped into the abdominal cavity? 4. What are the diagnostic symptoms of Retroflexion of the Uterus? What treatment would you adopt to cure this condition? 5. Distinguish between central and periosteal growths, (*a*) as to their situation in connection with a long bone, and (*b*) as to their microscopical characters. 6. In what diseases is there pigmentation of the skin? In what part of the skin does it accumulate? On what may it depend? 7. Describe a microscopical section of Nutmeg Liver. 8. Mention the situations in which pigmented Sarcomata are found; and describe briefly a microscopical section of a pigmented growth.

Ode to Autumn.

O Autumn! third daughter of Nature! Season of pheasant and poetry! Time of the Fall of the Leaf!
O Autumn! in thee I fancy new delights unknown to the common or vulgar variety of poet!
O Autumn! I am, like Nature, tint and tainted with thy "Rot," so I must write a poem or suppurate!
O Autumn! Season of "Flue" and "Dip!" of College Exams. Time of the Fall of Man!
O Autumn! wherefore art thou Autumn!
—It is a confounded nuisance to think of rhyme and attend to the metre—
So I will just string a few observations, Whitman-like,
In the style so much practised by poets of to-day,
And lo, O Aut! critics will arise and demand for me the Laureateship.

O Season of Rain! of "Rugger" and "Soc.!"
Of "Treves" and "Taylor" and all the lot,
Of "Fagge" and "Foster" and "Hilton's 'Pain'"
Without that "Rest," we sigh for in vain.
A season of colds, catarrh and sneezes,
Of racking coughs, and bronchial wheezes,
A time of Dems. and Bones and Spectres.
Of crowded clinics and dreary lectures.
Of boils in the nape, and broils in the State,
Of Peers and Lords to be torn to a shread,
Of Cæsar dying, and "The Empire" dead.
Of Cant and Chant, and the L. C. C.
Of Virtue and Vice! of Ruin and Sham;
Of the brand New Woman; and the same Old Man!
Of!—but wherefore should I "of"?
Let Mongals perish and Japs decay!
No more of this do I mean to chime,
Nonsense in prose, or dislocated rhyme.
The Editor tells me I'm off my "chump,"
But I've merely a dose of Autumnal "hump."

B. B. H.

Sport.

Rugby Football.

GUY'S v. CATFORD BRIDGE.

Played on our ground on Saturday, November 10th, resulting in a win for Guy's by 3 points (one try) to nil. A bright day and prospects of a good game induced some 500 spectators to turn out to see this match. We are pleased to state over 380 paid gate-money; this is a record for the ground, and promises good things in future. The turf was in good condition, the sky was blue, and only the language of the Hon. Sec. obscured the horizon. During the first half, the game was open and interesting, the forwards heeling out and giving the backs plenty of opportunities; some pretty passing was seen, but just before half-time a deluge of rain with wind, thunder and lightning spoilt all sure passing, and confined the game mainly to the forwards, the backs being useful in defence, and as ornamental as the mud would allow. A rather late start was made, owing to the late arrival of the referee, and one of the opposing team. Bell having won the toss, Guy's defended the pavilion end, taking advantage of what little wind there was. Catford Bridge started the game with a long kick, and Alexander touched down. Hancock dropped out from the twenty-five and play settled down in the centre, the forwards began immediately playing to their backs, some pretty passing being indulged in, which carried the game well into the Catford half. Our forwards heeling out smartly, our backs got a chance, and Hancock passing to Bell, the latter might have scored had he not strained his leg. He retired to full back, Alexander taking his place. Some give and take play ensued, when the halves getting the ball smartly away from the scrum, it was passed in turn through Alexander and Hancock, the latter transferring to Wetherell, who culminated a pretty piece of play by scoring well out on the right. The kick, a difficult one, taken by Hancock, was not successful. Until the rain came, Guy's continued the attack, but without success; after this the mud seemed to suit our opponents' forwards, and play ruled even to half-time.

A long wait was here indulged in, owing to the referee and touch judges seeking external covering and internal comfort. On re-commencing, our forwards rushed the ball down the ground, but were driven back by the sensible kick and rush game wisely adopted by our opponents. Owing to this, Catford several times looked dangerous, and we had to touch down several times; we in turn attacked, and a good dribble by Dykes enabled him to cross the line, but the referee ruled a scrum at five yards; the kick and rush game again drove us back, and some exciting scrimmages took place close to our goal line, but a clever dribble by Rowlands up the touch line relieved us. Up to the call of time, even play ensued, loose scrambling, forward work being the chief characteristic, the game ending about half way. Teams:—

CATFORD BRIDGE.—T. M. Heaward (back); A. P. Roe, G. Steel, A. H. Hume, and L. B. Meredith (capt.) (three-quarter backs); W. E. Calver and H. B. Smith (half-backs); F. S. Bishop, T. Hunter, F. Golding, C. F. Phillips, G. Pearce, A. R. Startup, H. Startup, and F. L. Turner (forwards).

GUY'S.—K. B. Alexander (back); H. T. Bell (capt.), W. I. Hancock, F. C. Wetherell, and D. F. Rae (three-quarter backs); A. Guy and R. S. Thorpe (half-backs); H. W. Dudgeon, R. J. Rowlands, C. R. Nicholson, N. H. Pike, M. D. Wood, P. A. Dykes, P. D. Hunter, and J. N. C. Gardiner (forwards).

Referee: Mr. A. D. Longinotto.

REMARKS.—For the first time this season we had our full three-quarter line, Hancock returning to his place at centre, the combination when the ball was dry being decidedly good. We were pleased to see "Guy" in the field again; he promises to get back his old form again. Thorpe must try to play more with his fellow-half, and pass less widely to his three-quarters. The forwards as a pack, played well for the first thirty minutes; they got the ball and let it out smartly, which is a great improvement, but it came out too often at the side. The latter half of the game they deteriorated and seemed unable to suit their play to the state of the ground.

GUY'S 2ND XV. v. LONDON AND WESTMINSTER BANK.

This match was played at Denmark Hill on Saturday, November 3rd, and resulted in a win for Guy's by 1 try to nil.

Losing the toss, we kicked off against wind and rain. Owing to the state of the ball and the ground, the game was of a very scrambling nature. Hicks scored the only point of the game, towards the end of the first half. The kick, which was a very difficult one, was unsuccessful. Nothing further was scored, and we won, after a hard game.

Our forwards played a splendid game, and were quite a match for their much heavier opponents. Hicks at half and Walling at back were the best of the outsides. Team:—

GUY'S.—H. B. Walling (back); J. J. E. Biggs, W. H. Barrow, Doyle, and W. T. Clarke (three-quarters); H. T. Hicks and Kinsey-Morgan (half-backs); A. J. Cleveland, E. G. Goddard, A. H. Saward, H. V. Bagshawe, A. H. Carter, W. F. Lindsay, G. Shorland, and Norman Williams (forwards).

GUY'S 2ND XV. v. CURRIE'S SCHOOL, FOLKESTONE.

This match was played at Folkestone, on Saturday, November 10th. Winning the toss, we decided to play down the gradient. Our forwards were all abroad for the first five minutes, but then they settled down and heeling the ball out splendidly, gave the half-backs plenty of chances. E. Morgan picking up the ball near our opponents' twenty-five flag, scored under the posts after a very pretty single-handed run; the place kick was unsuccessful. Continuing to have much the best of the game, E. Morgan scored twice in quick succession, Hicks converting the first try. The latter player was the next to score, after a very good run, but the kick was again a failure. After the kick-out a scrum took place in their twenty-five, and E. Morgan picking up in the loose, passed to Mathias who got in between the posts, Cleveland converted. At half-time we were leading by 2 goals, 3 tries, to nil.

With the wind and hill against us, they managed to keep us out for some time, until Hicks, picking up near the half-way line, dodged their backs, and after a good run scored near the corner flag; Barrow's kick was a failure. Our forwards were now dribbling well, and several times looked like scoring, and eventually, Kinsey-Morgan, picking up, scored far out, the kick again failed. Nothing more was scored, and we won as stated above.

Our forwards played a good game after the first five minutes, Carter, Goddard and Saward being the pick. Mathias and Morgan played very well, but the latter gave very few chances to his three-quarters. Hicks and Ransford did well when opportunities were offered them. Walling at back had but little to do. The place kicking was extremely weak. Team:—

GUY'S.—H. B. Walling (back); H. T. Hicks, A. C. Ransford, W. H. Barrow and W. T. Clarke (three-quarters); R. Mathias and E. Morgan (half-backs); A. J. Cleveland, E. G. Goddard, A. H. Saward, H. V. Bagshawe, A. H. Carter, Kinsey Morgan, G. Shorland and Norman Williams (forwards).

Association Football.

GUY'S 1ST XI. v. FERRY WORKS.

SURREY CUP TIE.

Played at Thames Ditton, November 3rd, and won by Guy's by 10 goals to 2. From start to finish the Hospital had the best of the game, and out-played their opponents. The Hospital kicked off, and taking the ball down the field, Palmer scored. Within five minutes Palmer scored another goal. Stamford notched a third point shortly after, the result of some pretty passing among the Guy's forwards. Ferry Works now waking up, began to press, and taking advantage of some laxity on the part of the backs, scored their first goal. Fitz-Hugh, however, taking the ball down the field, nearly beat the goal-keeper, who, in saving, had to concede a corner. A good place by Walker resulted in Humphry scoring the fourth goal for the Hospital. Half-time—Guy's, 4; Ferry Works, 1.

In the second half, Guy's had again the best of the game. Fitz-Hugh notched another point shortly after starting, and a misjudgment on our goal-keeper's part enabled Ferry Works to score their second goal. Fitz-Hugh (2), Palmer (1), Manby (1), Stamford (1), also scored; and the game ended in Guy's favour.

The day was very wet, and the play, considering the state of the ground, was excellent. Fitz-Hugh, Manby, and Stamford were the pick of the forwards, Crosby and Carter of the back division. Team :—

Guy's.—H. M. Barker (goal); A. B. Carter, F. J. Lidderdale (full-backs); Crosby, Crew, Walker (half-backs); Fitz-Hugh, Stamford, Palmer, Manby, Humphry (forwards).

Golf.

BROMLEY AND BICKLEY v. GUY'S.

This match, the first played by Guy's, took place at Bickley, on November 10th, in fine weather, with the exception of the last half-hour, when a heavy shower stopped play for the day. Guy's were unfortunate in losing the services of Coventry and Hamblin-Smith, two of our foremost players, otherwise the result would have been a closer one. After a very pleasant match the teams adjourned to a cottage on the links for tea, and so brought an agreeable day's outing to a close. Teams :—

Bromley and Bickley.		Guy's.	
Rev. F. W. Haines ...	5 up	P. R. Lowe...	0 up
Drysdale	6	F. G. Thomas.....	0
Simpson	1	E. N. Scott	0
Rev. C. Shuter	4	C. Shepherd.....	0
Tattersall.....	0	H. Munro	0
Tattersall.....	6	E. E. Henderson ...	0
Morris	3	G. E. Duncan.....	0
Morris	12	E. A. Peters	0

A committee meeting of the Golf Club was held in Dr. Fawcett's room in the College, on Monday the 5th inst., with Mr. Tubby in the chair. A letter was read from Mr. Laidlaw Purves, giving his views on the question of ground and the best way of obtaining one. It was decided that the different Hospitals should be canvassed by members of the committee, and lists of men willing to join made up; Mr. Laidlaw Purves kindly promising to get the names of any medical men likely to play. Any new players willing to join are requested to give their names in to Mr. Shepherd.

Negro Correspondence.

The following is an exact copy of a letter sent to a medical man by a negro in destitute circumstances :—

"Respectfully showeth—Your honour's servant is poor man in agricultural behaviour and much depends on seasons for staff of life. Therefore he prays that you will favour upon him and take him into your saintly service that he may leave some permanently labour for the support of his soul and of his family. Wherefore he falls on his family's bended knee and implores to you of this merciful consideration to a damnable miserable like your honour's unfortunate petitioner.

"That your Lordship's honour servant was too much poorly during the later rains and was resuscitated by much medicines which made magnificent excavations in the coffers of your honourable servant, whose means are already circumcised by his large family of five female women and three masculine, the last of whom are still taking milk from Mothers chest and are damnably noiseful through pulmonary catastrophe of the interior abdomen, besides the above named an additional birth is through the Grace of God very shortly occurring to beloved wife of bosom.

"That your honour's damnable servant was officiating in several capacities during the past generation but has become too much old for espousing hard labour in this time of bodily life, and was not drunkard, nor thief, nor swindler, nor any of these kind but was always pious and affectionate to his numerous family consisting of the aforesaid five female women and three masculine, the last of whom are still milking the parental mother."

C. M. B.

Calendar of Coming Events.

Nov. 17th.—1st XV. v. Lennox, away.
2nd XV. v. Lennox, home.
1st XI. v. Gravesend, away.
Smoking Concert in College, at 8.

" 19th.—Final Fellowship Examination begins.
1st XV. v. Leeds, home.

" 22nd.—Christian Union. Address by Dr. E. Calthrop, "Soul Growth."

" 24th.—1st XV. v. Coventry, away.
2nd XV. v. Middlesex Wanderers, home.
1st XI. v. Maidstone, away.
2nd XI. v. Beckenham, home.
Physical Society. Pathological Evening.

" 29th.—Christian Union. Missionary Meeting. Mr. Symonds will preside.
Address by Rev. R. Wardlaw Thompson.

Pass List.

Royal College of Surgeons, England, November, 1894.

First Fellowship Examination.

Howell, J.	Ormond, A. W.

L.D.S. Examination.

Cave, U. E.	Lambert, F. E. L.
Godfrey, T.	Morris, L. F.
Howitt, H. G.	Pilcher, J.
Hutson, E.	Stabb-Johnson, E. W.

Death.

KIRKMAN.—On November 3rd, at Hastings, William Phillips Kirkman, M.D., aged 67.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* MR. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

DECEMBER 1, 1894.

The Public Neglect of Medical Education in London.

To one who holds that the evil of all things educational in the career of the Medical Student of the day is the position so long occupied by the London University, the discussion recently raised upon the above subject in the columns of *The Times* will be to outward appearance a veritable *bonne bouche*, if the "public neglect" is looked upon as a consequence of the failings of the University. Is not the sequence rather in the opposite direction? If such a general philanthropy as is desirable followed the appeal, then would be obviated the necessity for the Gresham or other separate teaching university, which no one of its proposers expected or hoped to be self-supporting, and which would necessitate the aid of charity in the same way collectively as the majority of medical schools do now individually. From this it is obvious that the aspect of a Teaching University in London is quite outside the controversy.

In dealing briefly with the correspondence on the subject, we shall only mention the original article and *The Times* leader, as the other writers have either only corrected the "opener" or made points of detail, or have aired their own opinions or grievances on subjects quite outside the question.

With regard to the original article in *The Times* of the 24th ult., we can only echo the opinions of the writer when he states the public idea of a student's hospital life, and yet while doing so we can hardly believe that anyone should expect it possible for a man with such a Bob Sawyer's training to be worthy of the implicit confidence which is continually reposed in the present medical man. In no other profession than that of the medical can it be more truly said that "tempora mutantur": our curriculum is altered from an average of two and a half to six years (an average a year lower than *The Times* correspondent allows), with an increase of fees, and this alteration is entirely due to the rapid progress of Medicine and allied sciences, of which each student must now possess a competent knowledge. As Dr. Wilks so aptly pointed out in his recent address at Oxford, each of these discoveries has been due to and marked by the production of some new instrument, which instrument every one of us must be familiar with, both practically and theoretically—and not only theoretically as formerly; and yet a public expecting all these things from us has not made the feeblest effort of exchange in the hygienic bargain.

There is no profession, not even the Clerical, in which so much entirely gratuitous labour is

performed for the public good; and yet, if things are to go on in the present state, such sacrifices must be increased to be adequate. *The Times'* leading article deals calmly, almost flippantly, with the picture of the lecturer denying himself his already-insufficient fee, quite forgetting that a large percentage of the Teaching Staff—its junior members especially—must, in a great measure, depend on such a sum for their bread and cheese; and again, it takes umbrage because the former correspondent averages the remuneration of the forty teachers at £300—characterizing it as excessive. Does the writer suppose that the leading surgeons and physicians of great reputation can afford to give up some of the best hours of the day for even such a sum? Obviously in their case the fee must exceed the average which other teachers do not reach.

One more point and our brief *résumé* is done, we need not deal with the question of the "one endowed Hospital in London whose Governors possess surplus funds that are available for the purposes of education," as unaffecting the question in general, and ourselves in particular. The question "of the highly-paid professorship" is impossible; increased scholarships, even if not "filling the wards and lecture-rooms with men imperfectly prepared by preliminary education" would not solve the difficulty. If not by philanthropy, then by State aid must the question be settled, following the example of Zurich (quoted in *The Times*), or any other continental university, and at a time when legislation is ordering us how long we shall work, and in what manner we shall amuse ourselves, we shall be put to the further shame of having the sums fixed which are to be expended on charity illumined not with right feeling but by the false glare of party feeling and red-tapeism in order that each medical school's average annual deficit of £12,000—"a difference between the cost of teaching a highly technical and scientific subject, and the sum which the pupils are able to contribute towards their education, by no means unusual"—may be met equally among the many, and not fall on the already bowed-down backs of the self-sacrificing few.

Dental Caries.

Notes of Lectures by Mr. Newland-Pedley.

Dental Caries is not a disease, but merely a disintegration of the tooth, commencing on the surface and extending towards the pulp; produced by chemical agency, aided by certain "germs."

Phenomena.

In enamel.—Caries attacking a smooth surface shows an opaque area due to porosity—similar to a section acted on by dilute acid—but with unusual pigmentation.

Microscopically:—

(*a*). Prisms unduly distinct, granular, dotted.
Intervening spaces larger.
Axis of fibre attacked especially.
Pigmentation.

(*b*). Breaking up into granular debris.

In dentine.

(*a*). *Softening* extending along the dentinal tubes in the shape of a cone, with apex towards pulp. The cone is absent in spreading caries.

(*b*). *Pigmentation* and discoloration from germs and food.

(*c*). "*Tobacco-pipe*" *appearances.* Due to partial decalcification of the dentinal tubes, almost restoring the outline of the formative cells. The lumen of the tube is enlarged by collections of germs. The apparent hypertrophy of the dentinal sheath is produced by the partial decalcification of the matrix around the tubes, effected by the action of solvent fluids obtaining access to the matrix through the tubes; the intertubular substance is first attacked; the sheaths of Newman resist to the end.

(*d*). *Debris*, containing broken-up dentinal tubes.

(*e*). *Translucent zone.* Is a bright area surrounding the carious cavity. It may take the form of a complete or incomplete arc, or a line of bright dots; similar in nature to the transparent, horny tissue of stumps of old teeth. The opacity of dentine is due to the difference between the refractive index of the matrix as compared with that of the dentinal tubes and their contents. The translucency of dentine would be increased by decalcifying the matrix or calcifying the contents of the tubes. The translucent zone is an area of partially decalcified dentine.

(*f*). *Globular masses of calcareous salts.* Are sometimes seen in the dentinal tubes of carious dentine. They are depositions from solutions of salts of lime set free by caries; similar in nature to calcospherites (salts of lime and albumin).

(*g*). *Pain.* Varies. Is greater when the sensitive layer just beneath the enamel is attacked. Sometimes there is no pain in caries, and destruction of the pulp.

(*h*). *Leptothrix Buccalis.* With oidium albicans and protococcus dentalis; cryptogams (plants bearing no flowers) belonging to the algæ family, are found penetrating the softened tooth substance.

(*i*). "*Germs.*" Micrococci, oval and rod shaped bacteria, and bacilli are found in carious dentine. The micrococci crowding the dentinal tubes are in pairs (diplococci), in groups (staphylococci), and in chains (streptococci). Milles and Underwood described them as filling and bulging the tubes, extending in single file even beyond the area of visible decay, like the advance guard of an army. Pigment germs are also present, producing yellow-brown, black, green colour. Torula, a pure fermentation germ, is often found.

In cementum.—The decalcification and germ invasion extend along Sharpey's fibres, and germs are found crowding the lacunæ and canaliculi.

THEORIES OF CARIES.

"*Vital.*"—Definition: "Something which, for its occurrence in that particular place, is dependent upon the tooth forming a living part of a living organism."

In support of the "vital" theory—

(*a*). "Caries-interna." Sections of decayed teeth showed cavities in the dentine which did not, apparently, communicate with the surface; but had the section been carried through a different part of the tooth, the breach in the enamel would have been revealed.

(*b*). Abbott's inflammatory theory. Attributing caries to the inflammatory proliferation of the plasma that permeates dentine.

Objections to "vital" theory—

(*a*). Caries does not commence around inflamed pulp.

(*b*). Filling arrests decay instead of producing traumatic inflammation of dentine.

(*c*). Caries of a pulpless tooth is the same as that of a living tooth.

(*d*). Degeneration of the tissues of the tooth, free from caries, cannot be demonstrated.

(*e*). All the phenomena of caries can be produced artificially.

Abbott probably mistook collections of debris and germs for masses of protoplasm of high organization.

"*Chemico-vital.*"—Definition: Caries is produced by external agencies (acids chiefly) acting on tissues of which the vitality has, from constitutional causes, become depressed.

In support of "chemico-vital"—

Caries is rapid in wasting diseases such as typhoid; and in pregnancy.

Against—

Pivots, ivory blocks, and pulpless teeth decay rapidly under these conditions.

The use of the tooth-brush is generally neglected.

In support of "chemico-vital"—

The transparent zone was supposed to be a reparative effort of the pulp, effecting the calcification of the contents of the dentinal tubes.

Against—

(*a*). It is a stage in the decalcification of dentine.

(*b*). Can be produced artificially.

(*c*). Is seen in caries of pivots, blocks and pulpless teeth.

In favour of "chemico-vital"—

The "tobacco-pipe" appearances of the dentinal tubes were supposed to be due to hypertrophy.

Against—

They are due to decalcification of matrix around tubes.

Are seen in caries of pivots, etc.

In favour of "chemico-vital"—

The calcareous deposits in the dentinal tubes were supposed to be evidences of a reparative process.

Against—

(*a*). They are deposits from solutions of lime salts.

(*b*). Seen in caries of pivots.

(*c*). Can be formed artificially.

In favour of "chemico-vital"—

The varicosities in dentinal tubes were supposed to be evidences of pathological action.

Against—

They may be normal.

May be caused by collections of germs.

In favour of "chemico-vital"—

The apparent arrest of decay in shallow cavities was accepted as proof of repair.

Against—

Is due to the fracture of undermined edges of enamel forming self-cleansing surfaces which become polished by attrition.

"*Leber and Rottenstein's theory.*"—Definition: The teeth are decalcified by acid solutions and the work of destruction is completed by Leptothrix Buccalis.

If we use "Leptothrix Buccalis" as a generic term including transitional forms of many germs, the theory of Leber and Rottenstein is sufficiently correct.

"*Chemical Theory.*"—Definition: Caries is the result of acid solutions aided by certain "germs" acting on teeth of more or less defective structure in dental arches that are, as a rule, crowded.

Acids are:—

Lactic, acetic, butyric, malic, citric, formic proprionic, etc. Derivation—

(i.) Fermentation products of food and buccal mucus; through agency of "germs."

(ii.) Acids introduced into mouth with food.

(iii.) Acids regurgitated from stomach.

Rôle played by germs:—

They gain access to the cavity, multiply, accumulate, bulge and amalgamate the dentinal tubes. By their

agency food is decomposed and acids are formed; at the same time the germs peptonise the organic constituents of the matrix.

One cannot conceive that germs could penetrate the enamel without previous decalcification, and sections show decalcification extending beyond the germ line. The germs furnish the acid, and then complete the destruction of the decalcified matrix. Miller of Berlin has produced all the phenomena of dental caries, artificially, in teeth removed from the mouth.

The chemical theory is right.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	2.	Mitral regurgitation.
	4.	Chlorosis.
	7.	Aortic regurgitation. Embolism. Right hemiplegia. Left optic atrophy.
	14.	Aortic regurgitation and mitral stenosis.
	16.	Ulcerative endocarditis.
	20.	Mitral regurgitation. Hypertrophied and dilated heart. Tubal nephritis.
	25.	Pericarditis. Aortic and mitral regurgitation.
	41, 42, 46.	Chlorosis.
	49.	Mitral and tricuspid regurgitation.
Philip	1.	Mitral stenosis.
	13.	Thoracic aneurysm.
	36.	Mitral regurgitation.
Stephen	6.	Mitral stenosis and regurgitation.
	16.	Mitral regurgitation. ? Aortic stenosis. Hypertrophied heart.
	25.	Aortic regurgitation. Mitral stenosis and regurgitation.

Nervous System.

Mary	3, 5, 6, 31.	Chorea.
	8.	Delusions.
	12.	Cerebellar tumour. Optic neuritis.
	15.	Aphonia. Hysteria.
Philip	5.	Malarial neuritis.
	10.	Right hemiplegia and aphasia.
	14.	Fits. Cerebellar tumour.
Stephen	9.	Paraplegia. Spinal caries.
	10.	Sciatica.
	12.	Cerebral tumour. Optic atrophy.
	21.	Peripheral neuritis.
	31.	Right hemiplegia and aphasia.

Alimentary System and Abdomen.

Mary	19.	Hæmatemesis. Anæmia.
	20.	Ascites. Enlarged spleen. ? Cirrhosis of liver.
	24.	Neurotic dyspepsia.
	29.	Ascites. Cirrhosis of liver.
	35.	Abdominal pain. Abdominal tumour. ? Hydronephrosis.
	38.	Malignant stricture of œsophagus.
	39.	Abdominal tumour. ? Carcinoma of stomach.
Philip	2.	Dysphagia. ? Stricture of œsophagus.
	15.	Gall-stones.
	17.	Ascites. ? Perihepatitis. Bronchitis.
	24.	Ascites. Cirrhosis of liver.
	31.	Dysentery.
Stephen	3.	Ascites. Cirrhosis of liver.
	39.	Carcinoma of stomach.

Typhoid Fever.

Mary	8, 11, 32, 37, 45, 50.
Philip	6, 34.
Stephen	19, 24, 34, 37.

Genito-Urinary System.

Mary	18, 35.	Diabetes mellitus.
	22.	Chronic interstitial nephritis. Mitral regurgitation.
	43.	Chronic nephritis. Ascites.
Philip	11, 21, 30.	Diabetes mellitus.
	22, 38.	Chronic tubal nephritis.
Stephen	11.	Diabetes mellitus.
	13.	? Nephritis.
	23.	Chronic tubal nephritis.

Respiratory System.

Mary	36.	Pleuritic effusion.
Philip	3.	Obstruction of superior vena cava. ? Aneurysm. ? Mediastinal gumma. Paralysis of left vocal cord.
	23.	Chronic bronchitis.
	32.	Pleuritic effusion.
Stephen	7.	Pleurisy. Spinal caries.
	14.	Empyema.
	27.	Chronic laryngitis.
	31.	Left pleuritic effusion.

Phthisis.

Mary	17.
Philip	21.
Stephen	3, 32.

Miscellaneous.

Mary	26.	Raynaud's disease.
	44.	Psoriasis.
Philip	18.	Pain in back. ? Cause.
	37.	Eczema.
Stephen	8.	Tuberculous joints.
	15.	Addison's disease.

Rheumatism.

Mary	27.
Philip	16, 33.
Stephen	22, 29.

In the Surgical Wards.

Cases under Mr. Howse.

Accident 18. Compound fracture of metatarsal bone.
21. Concussion. Hæmatoma.
30. Compound depressed fracture of skull. Elevation of fragments.
32. Ruptured urethra. Extravasation of blood and urine. Perineal section. Catheter tied in through urethra.

Naaman 16. Tubercular gland in neck.
17. Appendicitis. Swelling in course of ascending colon. Fæcal. Swelling in iliac fossa, subsided largely before admission. Case a fortnight old.

Charity 12. Epithelioma of tongue. Woman of 49. Old superficial glossitis. Dyspepsia.
16. Tumour of breast.
Cot. Retention of fæces: septum short distance from anus. Division. Doing well.

Cases under Mr. Davies-Colley.

Cornelius 18. Senile gangrene. Amputation through thigh.

Lydia 4. Calculous pyonephrosis. Abdominal tumour. Foul urine. Nephro-lithotomy. Two branched calculi removed. Urine sweet.
9. Old fractured jaw. Previously wired. Ununited. Sinus persisting.
Cot. Cleft palate and hare-lip. Right side. Hare-lip operated on. Child six weeks' old.

Luke 2. Extreme case of congenital torticollis. Division of sterno-mastoid.
6. Small tumour top of tongue. Removal. Microscopically a papilloma.
7. Old ruptured urethra. Cystitis. Reopening of perineal wound.
11. Anal abscess.
18. Enlarged thyroid.

Cases under Mr. Lucas.

Job 1. Enlarged gland on inner wall of axilla. Removal. Microscopical examination shows it to be a small round-celled growth in well-marked reticulum; resembles lymph-gland structure closely. Lymphoma.
16. Recurrent lupus exedens of face.

Charity 2. Growth in bladder. Partial removal.
5. Abdominal fluid tumour. Ovarian.

Cases under Mr. Golding-Bird.

Cornelius 12. Concussion. Fractured base.
19. Compound fracture of humerus.

Martha 7. Appendicitis.
8. Flat foot.
16. Scalp wound. Linear fracture of parietal bone.
20. Thickened bursa patella. Fluid swelling subsided.

Lazarus 15. Candle in bladder. Supra-pubic lithotomy. Removal.
21. Necrosis of humerus.

Cases under Mr. Symonds.

Martha 13. (Philip private room.) Multilocular cystic adenomata of both ovaries. Removed.
13. Old lupoid ulceration of nose. Malignant deposits. Removal.
15. Enlarged thyroid. Palpitation. Pulse regular. Eyes a little prominent. ? Exophthalmic goître. Removal of lobe. Gland uniformly enlarged.

Cases under Mr. Lane.

Job 13. Appendicitis. Removal of appendix.
20. Appendicitis. General suppurative peritonitis. Appendix removed. Pus mopped out. Recovering well.

Case under Mr. Dunn.

Lazarus 2. Nodule attached to vas. Thickened vas. ? Tubercular.

With Dr. Horrocks at Out-Patients.

Case I.—Woman, aged 54, who had reached the menopause, having had amenorrhœa six years, came complaining of bleeding of two months' duration. No pain, no loss of flesh, or history of discharge. Hæmorrhage coming on so late in life as this makes you think of malignancy at once; notwithstanding the absence of pain. On examination, this patient was found to have atrophy of the uterus; a small mass like a fibroid polypus occupied the cervical canal; this did not bleed on touching, so was probably not malignant. On further examination, a urethral caruncle was found to be the source of bleeding.

Case II.—Woman, aged 25, complained of a bearing-down pain of a dragging character, and of something coming down outside. Her work involved much standing. On examination, the vagina and uterus were found prolapsed, and the supra-vaginal cervix was elongated; both lips of cervix much swollen and ulcerated at their most dependant parts; both anterior and posterior vaginal walls inverted and dry like ordinary skin except for the colour. Sound passed five inches. Vaginal fornices were depressed. Ulceration in these cases does not occur at the parts where there is most friction (*i.e.* at the sides where the inverted vaginal walls rub against patient's thighs), but always at the most dependant part,

as in this case. To distinguish elongation of the supra-vaginal cervix from infra-vaginal elongation, note that in the former the fornices are depressed, whereas in the latter you are able to pass your finger upwards for a good distance both anteriorly and posteriorly. The patient takes care always to sit on one side and so does not rub the protruding part. The prolapse is always easy to reduce; to retain in place a ring is the best instrument to use if it is sufficient support to retain it in place.

Case III.—Woman, aged 21, came complaining of pain at her monthly periods. On examination, the uterus was found to be nulliparous, anteflexed, and crescentic in shape. The symptoms this gives rise to are dysmenorrhœa and sterility. The dysmenorrhœal pains are somewhat analogous to labour pains; it is a uterine colic, and may be due to the passage of clots; for if the blood coagulates in the uterine cavity during menstruation the uterus will contract to get rid of the clot, and will give rise to pain as it is passing the bend of the anteflexion. There are two ways of treating this condition:—(1.) By Sims' operation, which allows a free exit for the discharge of menstruation into vagina. (2.) By dilating with Hegar's dilators.

W. A. C.

Cremation Compulsory.

"At yesterday's meeting of the City Commission of Sewers, the Sanitary Committee brought up a Report, submitting that it was highly desirable that a Crematorium should be erected at the City of London Cemetery at Ilford, and recommending that a public Bill be promoted in Parliament, to give the Commission the necessary powers for that purpose."

The above extract from the *Standard* of the 24th October shows that the practice of cremation is becoming rapidly popular with a large number of English people, and it may be well to place before our minds a few of the leading considerations affecting the question, with the addition of a suggestion or two arising out of the subject.

In dealing with the subject of Cremation, it may be of interest to give a short sketch of the history of the "burning of human corpses," as the custom has been defined.

Cremation appears to have been the general practice of the ancient world, with few exceptions—such as, in Egypt, where bodies were embalmed; in Judea, where they were buried in sepulchres; and China, where they were buried in the earth.

In Greece, only suicides, unteethed children, and persons struck by lightning, were not burned. At Rome, till the end of the fourth Christian century, burning on the pyre was the general rule.

Whether in any of these cases cremation was adopted or rejected for sanitary or superstitious reasons it is difficult to say. Embalming would probably not succeed in climates less warm and dry than the Egyptian. The scarcity of fuel might also be a consideration. The Chinese believe that they must have a properly placed grave in their own land; and with this view corpses are often sent home from California. Cremation is still the custom over a great part of Asia and America, but not always in the same form. Thus, the ashes may be stored in urns, or buried in the earth, or thrown to the wind, or (as among the Digger Indians) smeared with gum over the heads of the mourners.

There can be little doubt that the practice of cremation in modern Europe was at first stopped, and has since been prevented, in a great measure, by the Christian doctrine of the resurrection of the body.

Without entering into a religious discussion, it may simply be stated that Mr. Haweis, the celebrated preacher, appears to be a supporter of the practice, from his having written, *Ashes to Ashes: a Cremation Prelude;* and such persons as the late Lord Shaftesbury, who enquired, "What would in such a case have become of the blessed martyrs?" seem to have placed sanitation before superstition.

The subject, however, is chiefly a sanitary one.

The old practice, and disgusting results of pit-burial, made cemeteries necessary; but cemeteries are equally liable to overcrowding, and are often nearer to inhabited houses than the old churchyard. Although various regulations are laid down with reference to the selection of cemeteries, and the construction of graves, a certain amount of gas will escape in the air, or into sewage-drains, and thus reach houses, or will percolate so as to contaminate water which is afterwards used.

It is stated that the great Paris cemeteries cause headache, diarrhœa, and ulcerated sore throat to be suffered by those living in their immediate neighbourhood. It must also be remembered that the cemetery system can only be temporary. The soil is gradually filled with bones; houses crowd around; and the graves may be opened after a certain period.

For such disadvantages as these, the remedy is cremation. The subject has for years had a large number of supporters in Italy, Switzerland, Germany, France and Austria. In England the question was broached some two centuries ago; but Sir Henry Thompson first brought it prominently before the public, and founded, in 1874, the Cremation Society of London. Thompson's problem was—"Given a dead body, to resolve it into carbonic acid, water, and ammonia rapidly, safely, and not unpleasantly"; and it may confidently be asserted that that problem is accomplished by cremation.

It being admitted generally that, except from the points of view of sentiment and custom, cremation is desirable, it is necessary to enquire how the end can be gained, and in what manner the practice may be made universal in the United Kingdom.

For that purpose it is essential to ascertain what the modern British law is upon the subject. After the establishment of the Cremation Society in 1874, there

was some correspondence between the Society and successive Home Secretaries as to the legality of burning a body after death, but no satisfactory solution of the difficulty was arrived at.

In 1882 the matter came before a Court of Law, Mr. Justice Kay being the judge. The deceased had directed a friend of his (who was not one of his executors) to burn his body under a pile of wood, and also ordered his executors to pay his friend the expenses of such cremation. The friend brought an action against the executors and others, claiming repayment of the cremation expenses (the cremation having been effected at Milan), and Mr. Justice Kay decided that the case could not be sustained, one of the reasons given being that there can be no property in the dead body of a human being.

In the year 1884 the exact question of the legality of cremation came before the late Mr. Justice Stephen, who stated that he had the concurrence of another of the judges, Lord Justice Fry. A Dr. Price was charged at the Cardiff Assizes with having attempted to burn his child's body. He had placed the corpse in a ten-gallon cask of petroleum and set the petroleum on fire. A crowd collected, and the burning body of the child was covered with earth, and the flames extinguished. The charge of Mr. Justice Stephen to the Grand Jury on this occasion is full of interesting and learned information upon the subject of burial, but without going further into detail, the following passage of his conclusion as to the English law of the disposal of dead bodies may be quoted:—"After full consideration, I am of opinion that a person who burns instead of burying a dead body does not commit a criminal act unless he does it in such a manner as to amount to a public nuisance at common law"; and—what is rather important in connection with the suggestions to be made in this paper:—"As for the public interest in the matter, burning, on the one hand, effectively prevents the bodies of the dead from poisoning the living; on the other hand, it might, no doubt, *destroy the evidences of crime*. These, however, are matters for the Legislature, and not for me." It thus appears that there is nothing in English law to render cremation illegal, that the practice is now carried on, and although the system of registering deaths and granting certificates remains unaltered, cremation is authorised in England as a legal method of disposing of the dead.

Shortly after the decision in this case, a Bill was introduced into the House of Commons with the object of giving "additional guarantees for the detection of foul play before corpses are permitted to be buried, and to provide for the regulation of cremation," but the Bill was opposed by the Government and by the leader of the opposition, and thrown out by a large majority.

One great objection to cremation is, that rapid decomposition of the body removes all traces of poison or violence. Sir Henry Thompson says on this point, "Soon after burial distinct traces of most poisons—certainly those which are the most potent, such as morphia, aconite, atropine, strychnine, prussic acid, etc.—are sooner or later decomposed; or they may become associated with new septic poisons developed in the body itself, which complicate the steps of subsequent enquiry, and invalidate unquestionable evidences which were present for some days after death, and might have been obtained while the body was above ground. There remains then only the metallic poisons which can be reckoned on as likely to be detected after exhumation, practically three in number: arsenic, antimony and mercury," and he then goes on to suggest that before burial or cremation, an enquiry should be made by some competent official. In his *Modern Cremation*, Sir Henry Thompson makes the following recommendations, which are here reproduced shortly:—

1. No body to be disposed of without a certificate by a qualified medical man.
2. An official Certifier should be appointed in every parish to examine in all cases of death.
3. A Coroner's inquest should be held if necessary.
4. A license should be necessary before using a crematory.
5. Crematories to be open to Government inspection.
6. Burning of a human body otherwise than in a licensed crematory to be illegal.
7. Cremation to be sanctioned by the official Examiner.

It will thus be seen that cremation is simply tolerated by the law of England; but there is a certain amount of risk attached to having resort to the practice, for it is still an offence to cremate a body where such a course is likely to interfere with the holding of an inquest; and, moreover, there appears to be no effectual means of compelling the representatives of a deceased person to comply with their testator's wishes in this respect.

The object of this paper is to advocate a further advance as regards cremation. For the reasons already touched upon, I would make cremation compulsory in all cases. There would then be no sentimental objections on the part of the public; and no hesitation—not to be wondered at—on the part of the executors. The all-powerful force of an Act of Parliament would crush opposition, and every person would quietly acquiesce in the law of the land.

In conjunction with this universal cremation, and in order to meet many serious objections to the practice, my second suggestion is that a *post-mortem examination* should be held on every dead person. This should also be compulsory. In this way the true cause of death would almost invariably be discovered. Foul play would be detected, and the methods of poisoners found out. Moreover, the benefit would, perhaps, be of immense advantage to medical knowledge. Innumerable cases of difficult diagnoses, *e.g.*, abdominal and thoracic tumors, cerebral conditions, etc., would be made plain. Exhumations would be unknown, and such a horrible event as the case of burial alive, reported from St. Petersburg in the *Standard* as late as the 6th of October last, would be rendered impossible. Whether the post-mortem examination should be made

by the family doctor, or by an official of the Parish or the State, is a question. At all events, a report on the post-mortem should in every case of death be made to the official Certifier.

As regards the expense, the examination being for the benefit of the community, the cost should perhaps be borne by the Parish or the State. But it would possibly be well at first to treat the cost as a part of the funeral expenses, and in the case of paupers only should the Parish be called upon to bear the expenses.

An additional advantage, not to be lost sight of in these days of competition and of crowding in the medical profession, would consist in the additional employment and consequent remuneration for medical men; and many a student might look forward with confidence to attaining the not uninteresting position of an official post-mortem examiner.

The influential body of tradesmen known as undertakers would not suffer one whit, except perhaps as regards elaborate coffins. They would still be employed in "undertaking" a funeral, and would only have to change their methods slightly.

It is not suggested that coroners' inquests should be discontinued. On the slightest appearance of suicide or foul play, the post-mortem examiner should report at once to the coroner, who should then be bound to hold an inquest as at present. Not only the immediate cause of death would then be discovered, but also the indirect cause in the person of the murderer or suicide.

The suggestions of this paper may accordingly be broadly stated as follows :—

That cremation should in all cases be rendered compulsory, and be preceded by a post-mortem examination made by a duly qualified medical man.

Note.—The writer desires to acknowledge his indebtedness, among other works, to *Cremation*, by Mr. Aubrey Richardson, son of Sir B. W. Richardson, where the subject is admirably treated from a legal point of view.

H. CHARLES BATCHELOR.

Guy's Hospital.

Guy's Hospital Dental Department.

PRACTICE DURING OCTOBER, 1894.

Gold Fillings		394
Amalgam ,, ...		594
Osteo ,, ...		
Perm. G.P. ,, ...		
Regulations		6
Artificial Crowns		66
Dentures		11
Dead Teeth		204
Scalings		54
Attendance for Extraction under Anæsthetics	...	964
,, ,, without ,,	...	760
Total ...	...	3053

Medicine: a Science?

IT is not necessary to discuss at length the question whether medicine is a science. When we have investigated a man's condition with stethoscope and thermometer, have concluded that disease has laid hold of him, and have isolated, cultivated, and stained the tubercle bacillus, the conclusion that the patient is suffering from "tubercle" becomes a scientifically established fact.

Medicine, then, is a science—is it an exact science? It is at least less and less inexact every day. In the way in which medicine has been gradually rescued from mysticism and charlatanism, and definitely placed on the level of a recognised science, there is ground for great thankfulness and some pride; but in the unscientific way in which we approach the study of medicine, is there not ground for self-reproach? I think there is, and that in this we lag utterly and wilfully behind the sister sciences. Indeed, people are still to be found who affirm, with the late Dr. Moxon, that medicine is not a science at all. Clearly this is a heated and hasty statement; medicine is a science, and must as such be judged. Yet, though a hasty, I fear it is not a groundless charge; for how is the huge and growing mass of material handled with which medicine has to deal?

The question of classification lies, as everyone will admit, at the very foundation of the study of medicine. If it were a matter of option whether a method of classification were adopted, our present attitude would be comprehensible; but a science without a classification is like a gun without a barrel; it is an absurdity and an anomaly. I fear me that to-day, so far as regards intelligible and systematic classification of its materials, medicine is just such another anomaly as a barrelless firearm.

The writer of a text-book must arrange his materials somehow, and the method at present adopted of grouping diseases more or less indefinitely round organs or regions is surely about as bad a method as could be devised, and the first step towards interminable confusion. An alphabetical arrangement would be infinitely superior; this purely artificial and irrational method, besides, leads to manifold abuses.

To quote, by way of illustration, the first instance that comes to mind: If it were not customary to speak of "skin diseases" as embracing every disease which includes a visible disturbance of the skin amongst its symptoms, no one would venture to write down erythema nodosum as a disease. We all know that eryth. nod. is a symptom of a neuritis, and that the neuritis which causes this particular rash is itself the result of the presence in the circulation of some morbid material. When we have found the origin of this poison in an attack of rheumatism or influenza, we have reached probably a fundamental condition. The man who says "there is a valuable symptom, let us find its cause," is teaching the student to study medicine after a scientific

method. The man who says "this patient is suffering from erythema nodosum, and therefore comes to me as a dermatologist," is handling the disease, the patient, and the student in a thoroughly unscientific manner. He must either do this or cease to be a specialist.

The learned dissertations of the introductory chapters of medical works as to whether the germ, or the pyrexia, or the rash, is the disease; the inevitable answer that the disease is a subtle mixture of them all with the patient, and the equally inevitable deduction that we had better not attempt to classify such nebulous quantities; all this is surely, as I have said, beside the mark. It is ridiculous to say we must first define what a disease is before we attempt a classification. It is perfectly clear that practically a disease includes all departure from health which results from any given specific cause.

What should we think of the geologist who classified rocks according to the parishes in which they occurred? Our position is as ridiculous as his would be.

If medicine were not a science resting on the sure ground of nature, classification would indeed be hopeless. In the days when the human body in disease was considered as a battle-ground of gods and devils, and when the aid of priest-craft and sorcery was invoked to cajole or frighten the supposed belligerents, classification would have been a difficult matter, to say the least of it. But nowadays, when we recognise that every disease arises from some demonstrable physical cause, surely all this is changed.

The natural condition of the human body and mind is one of perfect health, and when this equilibrium is disturbed, some agent has been at work. However diffused the disease may be throughout the organism, and however complex or obscure the symptoms, we know that there must be a cause, and that this cause is a demonstrable quantity; herein we have a basis for the classification of the diseased conditions arising out of this disturbance of the natural equilibrium. For example:—In the case of rheumatism; we all know that the endo- and peri- carditis, the pleurisy and the peritonitis, are just as much integral parts of the disease as the joint affection, and generally of much greater importance. And yet, because rheumatism has been handed down to us as a "joint disease," we class its most vital parts as "complications." Why not recognise that the cone of which all these manifestations form part of the base, has an apex in some blood condition, of which as yet we know neither the nature nor the origin? The first step towards enlightenment is a recognition and a confession of ignorance. If we recognised that in order to classify a disease it was essential to have a clear conception of its origin, we would not be satisfied with the present position of rheumatism.

In the same way, orthodox people would have us believe that gout is a joint disease, that it is to be defined as a deposit of urate of soda in the joints; whereas we all know that gout means really an abnormal accumulation of uric acid, some defect in the chemistry of the individual, and that the evil effects involve the whole mind and body of the patient, and not his joints alone.

Again: could any disease be better calculated to give the student a broad view of his profession, if only its study were entered on in a scientific spirit, than tubercle? He would very soon find that to omit the examination of any organ, function, or secretion, is a mistake which is apt to have the worst possible consequences for his patient and himself. He would learn that he must deal with the human organism as the skilled workman deals with the cable-chain—the examination of each throughout its linked inter-dependence and indissoluble entirety must be carried out conscientiously. To overlook in either the single flawed link may lead to disaster. On the other hand, how is this perfect medium of instruction dealt with at present? It is chopped in pieces and thrown about to be scrambled for by specialists, and the poor student has to go to the gynæchologist, the dermatologist, the laryngologist, the ophthalmologist—not to mention the physician and the surgeon—begging to be allowed to inspect the scraps that he may make of them a medical mosaic—a pathological patchwork.

This plausible and dangerous system of specialization at once arises from our disorderly methods—or, rather, our utter want of method—of classification, and bars the way to its improvement. Until medicine is recognised as one great science, incapable of division without utter destruction as a science, the present rapid accumulation of detached facts positively makes the path of the student more difficult and obscure, instead of easier and plainer.

The plain-written medical text-books are being buried deeper and deeper beneath unsorted mountains of redundant special treatises, monographs, reprinted articles, and the like, which do much more to throw light on the business address of the author than on the subject or on the path of the student.

A little reflection will show that if all diseases were classified according to their causes, they would naturally fall into groups. Thus the fact that the cause originated either inside or outside the organism would lead to a division of diseases into two great groups. Diseases due to causes arising outside the organism would break up naturally into smaller groups—such as germ diseases; those due to poisons introduced from without; to mechanical violence, etc. Diseases due to causes arising within the organism would naturally group themselves round the organs or tissues primarily affected; hysteria and G.P.I. would figure probably as true diseases of the nervous system, and would not be thrown in with peripheral neuritis and tubercular meningitis—symptoms of well-recognised diseases. If this system were adopted, the staff of each of the great hospitals might by collaboration compile a real text-book of medicine whereby the student should understand clearly and once for all that his book-work and his clinical-work had for their object to make of him a worthy member of a great scientific body which has one object in view, and one only, namely—the patient scientific tracing of every

disease to its primary cause, so that it may be prevented, cured, or modified in as far as possible a scientific way. Then, surely, it would be evident to teacher and student, and ultimately to the public, that all specialisms and opathies are, and must be, unscientific, superficial, partial, and dangerous.

Now, to recapitulate briefly :—

There is only one science of medicine, and there is only one art of healing, and they deal with man as a man, and not as an anatomical model, which comes to pieces, so that we may make a separate study of the nose, the eye, the ear, throat, etc., as if diseases could be parcelled out to each part as separate and independent entities.

Nothing would bring home to the student so clearly the unity of medicine as a scientific classification of diseases; and seeing that every disease, no matter how complex it is or how widely distributed over the body, has some definite underlying cause, such a classification is possible.

Specialism, in the ordinary sense of the word, is incompatible alike with the scientific treatment, the straightforward teaching, and the unification of medicine, and should therefore be rigorously excluded from all the hospital schools, and discountenanced by the body of the profession.

South Petherton. S. W. MacILWAINE.

Calendar of Coming Events.

Dec. 1st.—1st XV. v. Bristol, away.
2nd XV. v. Beckenham, home.
1st XI. v. Old Brightonians, home.
January Appointment List opens.
Debating Society. Meeting in College Smoking Room at 7.30.

„ 3rd.—Examinations for M.D. and M.S. Lond. begin.

„ 4th.—Examination for B.S. Lond. begins.

„ 5th.—1st XV. v. East Sheen, away.

„ 6th.—Christian Union. 4.30. Dr. E. Calthrop. Address: "Four Fragments."

„ 7th.—1st XI. v. Marlow, away.
Cambridge First and Second M.B. Examination begins.

„ 8th.—1st XV. v. Old Merchant Taylors, away.
2nd XV. v. Sidcup, away.
1st XI. v. Eastbourne, away.
2nd XI. v. Holloway Sanatorium, away.
Physical Society. Meeting at 8. "Malaria." W. S. Handley.

„ 11th.—Cambridge Third M.B. Examination begins.

„ 13th.—Christian Union. 4.30. Rev. C. H. Bowden (Chaplain to Guy's Hospital), Address: "Bible Study."
Guy's Hospital London University Club Annual Dinner.

The Smoking Concert.

The first of the Winter "Smokers" was held on November 17th, under the Chairmanship of Mr. Slater. The Smoking-room was crowded with members and a large number of visitors, amongst whom was Mr. Fripp.

The proceedings were opened by Mr. Robinson, who gave, "They don't speak to one another now." He was followed by Mr. Spon, who sang, "When the boys come home." An old favourite, Mr. Coulson, gave us "Feodora," in which his voice was heard to perfection, and an encore being enthusiastically demanded, he sang "Sleep on, Dear Love." We were delighted to hear Mr. Wright's violin again; Joachim's "Cavatina" scored an undeniable encore, the famous Intermezzo from "Rusticana" being given in response. Roars of laughter formed the chorus of Mr. Allport's "I couldn't help but laugh"; and in response to repeated encores, he told us how a "donah" got serenaded by suitors of various nationalities. A humorous recitation by Mr. Miller, from whom we may hope for more on future occasions, fairly brought the house down, and on being recalled, he gave us a couple of good anecdotes. "No Class" was the next item, rendered by Mr. "Sidney George," all about "The Ditch" and the "Good Old Boro'," the last being a topical verse. "Mammy's little bally balmy Coon" next made an appearance, "impersonated" by Mr. Michael. A banjo quintette, "Black Bess," by Messrs. Michael, Scott-Turner, Dudgeon, Cann and Hill, brought the first half to a close.

The second half was opened by Mr. Hicks, a performer we should like to hear again, with "Sleep, my Love, Sleep." Mr. Robinson dilated on his "Happy little home," a contrast to Mr. Layman's account of the "Irish Parliament," which followed. Mr. Coulson next sang "The Moon is Shining Brightly" exceedingly well, succeeded by another beautiful violin solo by Mr. Wright. Mr. Poole sang the ever-seasonable German "Drinking Song" in good style, while Mr. Grace depicted the "Horrors" of a soldier's life, giving a very humorous recitation as an encore. Mr. Spon sang "The Admiral's Broom" with good effect. Mr. Michael with "Down the Road," Mr. Layman with "Sairey Ann," Mr. Spon with "Rumpty Tumpty," the "Fusillade" by the same banjo quintette, and the audience with "Auld Lang Syne," brought a very enjoyable evening to a close.

It is a pity that we seem to have to fall back almost entirely on old talent on these occasions, although some of our junior men proved their ability to do something last Saturday. We hope that more of them will offer their services for the next Smoker. F.

The College Baths.

The Warden gives notice that these will in future be reserved for the use of those Students residing in the College, each of whom may obtain a key from Miss Newton on payment of a deposit of five shillings.

Passim.

The Debating Society will meet to-night in the Club Smoking Room at 7.30 p.m. Mr. W. A. Carden will propose "That this House is of the opinion that the cause of Temperance would best be served by the introduction into England of a Licensing Scheme, based upon the Gothenburg System." Mr. J. A. Reaside is announced to lead the opposition.

Members of the Guy's Hospital Association of the S. Andrew's Waterside Mission are reminded that the Annual Sermons and Offertories are fixed for to-morrow (Sunday), December 2nd. Services at 7 a.m., 8.40 a.m., 11 a.m., and 7 p.m.

At the next meeting of the B.M.A., Metropolitan Counties Branch, South London District, which will be held in the Court Room (by kind permission of the Treasurer) on Wednesday, December 5th, at 8.30 p.m., Dr. Newton Pitt will read a paper "On some Cases of Aphasia." All practitioners and students are heartily invited to be present. Dr. Leonard Sedgwick will preside.

We should like to call attention to the letter which recently appeared in the Medical Journals, inviting subscriptions "for the erection of a memorial in Guy's Hospital" to the late Beavan Rake, and "for assisting his widow in establishing a Nursing Home in London and in the education of his children." Dr. Pye-Smith, of 48, Brook Street, is treasurer of the fund, and we feel certain that all Dr. Rake's many friends and admirers will not miss this opportunity of showing in a practical manner their appreciation of his vast services in the cause of Medical Science.

The discovery of new anatomical facts is such a rare occurrence that special value attaches to anything fresh which is brought to light. The report of the paper read by Mr. R. Clement Lucas before the Anatomical Society, which we are able to publish to-day, is therefore of peculiar interest to Guy's men, seeing who is its author.

Every reader of the Gazette is familiar with the name, at least, of "G. Sichel," appended to the inimitable sketches which from time to time it has been our good fortune to secure. All "Jerry" Sichel's work is on a par with his artistic productions—of the very best—and his conspicuous success at the late examination of Candidates for the Naval Medical Service is but another instance in point. To have obtained the first place with the record of 2,920 marks is a notable achievement, of which we can assure Mr. Sichel that his old Hospital is very proud.

It will surprise few men who are still, or were till quite recently, about the Hospital to hear that such is the success of the Clubs' Union that well over ninety per cent. of present students are members; but there is room for a little surprise, and for a great deal of gratification, at the splendid support which it has met with from old Guy's men. For the modest sum of one guinea a man who has passed beyond his active student course can become a life member of all the constituent institutions (of which the Students' Club, with its dining, reading and smoking rooms, is the most likely to be of real use to him), will receive for one year from the date of his entry the Gazette and Reports, and will have his name and address printed in the List of Members and Directory at the end of the annual Blue Book *for the rest of his life.*

Such a large percentage of old Guy's men's names already appear in the Directory that it has become the recognised reference for

social and professional communication among old colleagues, and it has been of great use on those frequent occasions when a practitioner is asked by a patient to recommend a doctor to be called in if required during a sojourn in a strange land. Upon this and other grounds it is much to be desired that the few old Guy's men who, from ignorance of its uses or, more likely still, from mere forgetfulness to reply to the circulars they have from time to time received, have not yet come into the fold should be induced to do so, and to this end a whip has just been issued to each and all of them. Will those who are already members help to forward the efficiency of the Directory by bringing personal influence to bear on any men they know whose names are not in the Blue Book? A little personal influence and the book will include the name of every Guyite alive, and not till then shall we be satisfied.

Further, we should like to remind life members that 12s. 6d. must be forwarded annually to the Medical School Office if they wish to continue to receive the Gazette and Reports; and we would ask every member (life and subscribing) to communicate at once with the Secretaries if there is any omission or error in the statement of his name and address in the current (1894) issue of the Blue Book.

It does not seem to be quite generally understood that members can only be admitted free to the Ground on match days if they produce the match list, with which they will be supplied on application to the Hon. Secs. of the Football Club. Ladies are always admitted free (and we have been delighted to see them there in such goodly numbers)—so are servants of the Hospital (if they apply to the Secretaries of the Clubs' Union for an order), soldiers, and servants (in uniform) of the London and Brighton and the Chatham and Dover Railway Companies.

Stimulated doubtless by the example of Guy's, the late Dr. Wooldridge's school friends have erected a tablet to his memory in the Chapel of Cranleigh.

IN . PIAM . MEMORIAM
LEONARDI . CAROLI . WOOLDRIDGE . M.D.
ALUMNI . CRANLEIENSIS . ILLUSTRISSIMO
QUI . IN . CHRISTO . OBDORMIVIT
ANNO . ÆTATIS . XXXII.
A.D. . VIII. . ID . IUN . MDCCCLXXXIX.
AMICI . HANC . TABULAM . POSUERUNT.

ARTE . SALUTIFERA . MORTEM . QUI . DISTULIT AEGRIS
IPSUM . NUNC . MORTIS . VIS . INOPINA . RAPIT
AT . QUID . FLERE OPUS EST? UBINAM VICTORIA LETI?
VIVIT . ADHUC . VITAM . DAT . SINE . FINE . DEUS.

We are informed that the new catalogue of the Pathological Museum, edited by Drs. Shaw and Perry, and reviewed in our columns in a former issue, may be had on application at the Medical School Office, price 7s. 6d.; also that the College Library catalogue, which has been but lately revised and is now up to date, may be obtained from the Librarian for the modest sum of threepence.

Pass List.

University of London, October, 1894.

M.B. EXAMINATION.

First Division.

Davies, H.
Leete, A. H.
Manning, G. E.
Steward, F. J.
Taylor, E. C.

Second Division.

Armer, A.
Carpmael, C. E.
Collier, H. W.
Hopkins, F. G.
Hovenden, A. C.
Hovenden, G. S.
Manning, T. D.

Royal College of Surgeons, Eng., Nov., 1894.

FINAL FELLOWSHIP EXAMINATION.

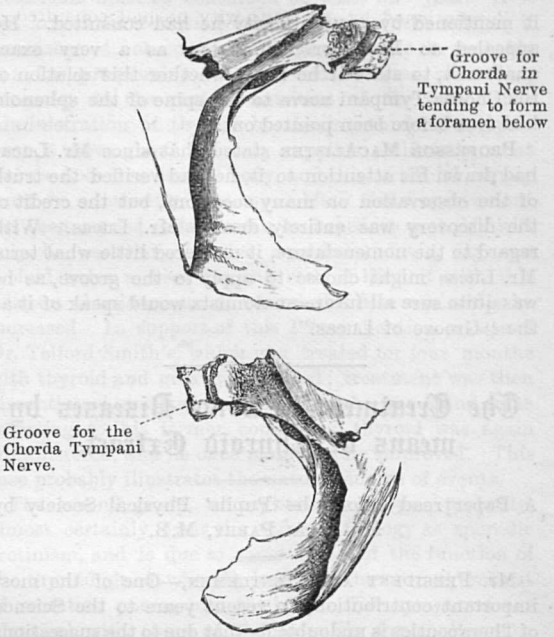
Cresswell, F. P. S.
Counsell, H. E.
Hall, G. C.
Luce, R. H.
Pantin, C. S.

The Groove of Lucas.

At the meeting of the Anatomical Society of Great Britain and Ireland, held at the London Hospital on November 19th, Mr. R. Clement Lucas read a paper "On an undescribed Groove on the Spine of the Sphenoid formed by the Chorda Tympani Nerve." He prefaced his remarks by saying that it was the custom to offer an apology for putting on record a new anatomical observation, which could not be shown to be of any great practical importance, or to which no interesting theory could be attached. This practice was much to be deprecated, since it indicated a feeling that unrecorded knowledge in anatomy required to be bolstered up by surgical use or be made of interest by supposing it to be a special design in Nature of uncommon import, before it could be received or adopted on its own merits. Happily, he continued, we have escaped from the time—some thirty or forty years ago—when disregarding all the teaching of development, all the modifications by use, or of decay from disuse, examiners inventing puerile theories of their own, expected students to attach these ridiculous romances to some anatomical fact before candidates for degrees could be approved for their profession. These misconceptions and misinterpretations of Nature's work added merely useless lumber to anatomical knowledge. He made no apology, therefore, for bringing forward a small anatomical fact, which he believed had hitherto been passed by unnoticed. Should it make more clear, precise, and definite the course of an interesting nerve, that alone he would maintain was sufficient to make it worthy of record.

The position of the canal of Huguier, by which the Chorda Tympani escapes from the temporal bone, was never very clear to a student, because its external aperture was lost in the recess between the squamous and petrous portions of the temporal bone, at the extreme inner end of the Glaserian fissure. Asked to indicate the position of this aperture on an articulated skull, a candidate will almost invariably point to the Glaserian fissure external to the spine of the sphenoid, some quarter of an inch too far out, whereas the nerve can be easily shown to lie in contact with, and to groove, the inner side of the sphenoid spine. To point out this important relation, of which the author could find no mention, was the object of his short communication.

The groove can be readily found on the inner side of any well-developed sphenoid spine a little posterior and internal to the foramen spinosum. It is from a quarter of an inch to three-eighths of an inch in length and is directed from behind downwards and forwards. In its course it frequently presents a slight concavity directed forwards, and at its lower limit there is often a notch at the edge of the spine. In one specimen, which was exhibited, the edges of this notch have so far grown towards each other as to form an almost complete foramen, just behind the foramen spinosum. (This case we show in our illustration.) In another, the



Sphenoid from Guy's Museum. No. 2.

course of the nerve is indicated by a canal, which actually perforates the spine and opens as a groove only at the lower edge. The groove is more or less pronounced relatively to the greater or lesser development of the sphenoidal spine, which is a part liable to considerable variation; but there are comparatively few spines on which some evidence of the groove cannot be detected.

The diameter of the groove corresponds to that of the slender nerve which it supports, but it may be noticed to widen, in certain instances, towards the lower part, as if the nerve were there subjected to a certain amount of movement. Considering that the Chorda Tympani soon applies itself to the lingual nerve, and that this attaches itself to so movable a part as the side of the tongue, it is not to be wondered that some trace of this transmitted mobility should find record on the bone, though the general tendency of the bony support will be to limit mobility and afford protection against muscular pressure.

In an articulated skull, the guide that best leads to the position of the groove, is the tubercle at the anterior extremity of the vaginal process of the temporal bone, just in front of the carotid canal. This projection of bone is immediately behind the groove on the sphenoid.

In conclusion, Mr. Lucas suggested that if a name were required to indicate this groove, the term "stria spinosa" or "sulcus spinosus" might be employed to bring the nomenclature into harmony with the name "foramen spinosum," used for the aperture of the middle meningeal artery.

In the discussion which followed,

Professor Cunningham, the President, said that the groove was quite new to him, and he had never found

it mentioned by any authority he had consulted. He appealed to Professor MacAlister, as a very exact anatomist, to state if he knew whether this relation of the Chorda Tympani nerve to the spine of the sphenoid had ever before been pointed ont.

Professor MacAlister stated that since Mr. Lucas had drawn his attention to it, he had verified the truth of the observation on many occasions, but the credit of the discovery was entirely due to Mr. Lucas. With regard to the nomenclature, it mattered little what term Mr. Lucas might choose to apply to the groove, as he was quite sure all future anatomists would speak of it as the "Groove of Lucas."

The Treatment of some Diseases by means of Thyroid Extract.

A Paper read before the Pupils' Physical Society by Mr. L. A. Parry, M.B.

Mr. President and Gentlemen,—One of the most important contributions in recent years to the Science of Therapeutics is undoubtedly that due to the suggestions of Brown-Séquard and others as to the employment of organic extracts in the treatment of disease. So far, with one exception, I believe very little success has attended the use of these substances—extract of suprarenals has not cured Addison's disease; insanity does not react to extractum cerebri; nor does bone marrow seem to have much influence on the progress of Hodgkin's disease, or pernicious anæmia.

The one exception to which I refer, and which I think justifies my statement as to the value of these suggestions, is thyroid extract. I think it is now acknowledged by even the most sceptical, by those most averse to the employment of new remedies, by the most conservative of physicians, that this extract has undoubtedly been of the very greatest benefit in the treatment of disease. The length of my paper to-night would be very great if I spoke fully of all those pathological conditions for which this substance has been recommended and tried, and I therefore propose to confine myself to those diseases in which it has proved of the most marked benefit, namely, myxœdema, including the congenital form of that affection, or sporadic cretinism, and various skin diseases. The rest, such as acromegaly and insanity, I shall only briefly refer to.

Firstly, myxœdema. Osler divides this disease into three great clinical groups—the congenital form, or sporadic cretinism, the ordinary form or myxœdema proper, and surgical or operative myxœdema. It is now recognised by all pathologists that these three conditions are due to a defective secretion of the thyroid gland; in sporadic cretinism a congenital absence of the gland, and therefore impossibility of secretion, in myxœdema, an atrophy or destruction of the gland, and in operative myxœdema, a removal of the gland. Although this has been known or suspected for some considerable time, it is a peculiar fact that it is only in the last year or two, during which time the pathology of this remarkable condition has become more fully studied and understood, and the researches of various well-known observers have finally and completely established the view, long suspected, that this disease is due to a loss of function of the thyroid, I say it is only quite recently that hopes of the possibility of relieving the symptoms, if not of fully curing the disease, were entertained. Osler, in his celebrated text-book, published as recently as 1892, states that it is evident that the thyroid gland supplies some essential secretion of the first importance, and that the disease is characterized by atrophy of the thyroid, and yet concludes by saying that no satisfactory treatment is known, never even mentioning or suggesting the use of thyroid extract.

The first form in which the treatment was tried was due to experiments on various animals, founded on deductions, drawn from observations on the pathology of this myxœdematous condition. It was found that if the thyroid of an animal were successfully transplanted from the neck to another part of the body, it was capable of continuing its function, and so preventing the onset of cachexia strumipriva. Mr. Horsley then suggested grafting a healthy sheep's thyroid into patients suffering from myxœdema as a means of arresting the progress of this disease. This was tried and immediate improvement was the result, showing that it could not be due to the gland becoming vascularised and functional, but could be accounted for by the absorption of thyroid juice into the tissues of the patient. The next advance was to inject a preparation of the gland into the subcutaneous tissues, a much simpler and more efficacious method; and, lastly, the most simple means of all was tried, administration of the drug internally. Only one more stage appears possible, that of transplanting the gland and its blood-supply, and thus getting it to become functional in its new abode, an operation difficult to imagine, and far more so to carry out.

The first division of this disease, sporadic cretinism or infantile myxœdema, is one of the most curious and interesting conditions met with in clinical medicine. I must first briefly run through the main symptoms presented by examples of this disease, in order to contrast the cases before and after treatment with thyroid. These sporadic cretins are always stunted in growth and intellect; their skins are thick, yellowish, rough and scurfy; they have short, broad hands, short fingers, and dry hair; there is a great increase in the subcutaneous areolar tissue; their tongues are large and thick, and often hang out of the mouth; their sense of the ludicrous is well developed, and they often take delight in making grimaces to excite laughter in the surrounding spectators; the face is large, the lower jaw drooping and saliva runs from the mouth; the legs are short and deformed; the head is broad and large, the nose flat at the root, so that the distance between the eyes is increased; the cretin often cannot speak, or can only say a few words; his

intellect is very childish; an umbilical hernia is generally present, and a kind of fatty tumour is found in each supra-clavicular fossa. These cases, after treatment by thyroid, which, by the way, must be continued for some time, show notable physical and mental improvement; they grow in length, often to a considerable extent; their intellect is developed, they become quite bright; their vocabulary is enlarged, they talk, and answer questions; the face loses its idiotic appearance, the tongue diminishes in size, and the skin becomes moister, softer, and smoother; the various parts of the body are all markedly developed; metabolism is increased; the bodily functions all become more active.

I will read as an interesting example, a short description of a case that was admitted into the Edinburgh Royal Infirmary, under Dr. Bramwell. The patient was a girl sixteen years old, but she did not look more than two, she weighed under two and a half stone, and measured 29½ inches; she could not stand, but could pull herself along a little way by her belly and arms; her intellect was a negative quantity; she never uttered a single intelligible word for the six weeks she was in hospital; her tongue was very large; she looked more like one of the lower animals than a human being; the expression of her face was that of a bulldog; the skin was harsh and dry, and she presented the usual pseudo-lipomata in the supra-clavicular fossæ, and a large umbilical hernia. As the result of treatment with thyroid, the œdematous infiltration of the tissues rapidly subsided, in the course of a few weeks disappeared; in a single week, the swelling of the lips, tongue and body generally, had decreased, and at the end of six weeks, the skin had become soft and smooth. In six months the patient had grown five and a half inches, *i.e.*, one-sixth her total length before treatment; she looked two years older, and was certainly more lively and intelligent. The extract is still being administered, and there is every reason to suppose that the improvement will continue.

As a case nearer home, and one in the power of all to observe, I may just briefly refer to a child attending Dr. Pitt's out-patients. He was a fairly marked example of infantile myxœdema. One slight peculiarity he had was that of insisting on shaking hands, first with the right and then with the left hand, with everyone in the room. He has been treated with thyroid extract, and has grown both mentally and physically. He can generally be seen at the Out-patient Department on Monday afternoons.

As to the details of treatment of these cases, in addition to the administration of thyroid, it is of great importance that they should be placed in healthy and hygienic neighbourhoods; they should be well fed and carefully tended; their guardians and nurses should be well-informed and capable of educating them; and thyroid extract must be administered. As a rule, one tabloid a day is sufficient; but a careful watch must be kept for symptoms of poisoning, to which I shall refer later, and the dose if necessary diminished. If no bad signs develope, the amount given may be increased. The treatment must be continued at least one year. It is not known for certain whether the cases will relapse if treatment is not continued longer, but this is probably so; for, presumably, the thyroid secretes something necessary to the perfect nutrition of the body. The administration of thyroid by the mouth does not produce a new gland; it only supplies artificially what Nature does in a normal body, and this artificial supply must be constantly kept up. After the improvement has been carried as far as can be hoped, it probably will only be necessary to give occasional doses, say one tabloid twice a week for the rest of life; if with this relapses should occur, of course the dose can easily be increased. In support of this I may mention a case of Dr. Telford Smith's, which was treated for four months with thyroid and greatly improved; treatment was then discontinued, and two months later he was found to be reverting to his former condition; thyroid was again administered, and he once more rapidly improved. This case probably illustrates the natural course of events.

The second group, or myxœdema proper, probably, almost certainly, owns the same pathology as sporadic cretinism, and is due to some defect of the function of the thyroid gland, whereby less than the normal amount of secretion passes into the body. The symptoms are identical with those of the infantile form, allowance being made for the fact that in the former it is the fully-developed body and mind that is being acted upon, in the latter the undeveloped structures. The main symptoms consist of pronounced failure of the mental faculties, slow and monotonous speech, apathy and dulness, deficient memory, delusions or convulsions, a remarkable swelling of the cutaneous and subcutaneous tissues, with dryness and roughness of the surface and absence of perspiration; the hair often falls out; the movements of the body are slow; the temperature is subnormal; the knee-jerk is absent, and the thyroid body is atrophied.

As long ago as 1883, Professor Kocher tried transplanting portions of a freshly excised thyroid gland for a case of this disease, but the transplanted portion was soon absorbed, and he did not follow up his treatment. Some years later other physicians revived this method, and transplanted pieces of the gland, either placing them in the subcutaneous cellular tissue, *e.g.*, of the breast, or leaving them loose in the abdominal cavity. They found, however, that the portions soon atrophied, and whatever improvement had taken place was rapidly lost. The patients again improved when a fresh piece of the gland was transplanted, but again relapsed when atrophy took place. Obviously, to effect a cure, these frequently repeated operations of transplanting portions of gland were necessary. Each operation is only equivalent to a good dose of thyroid, internally administered, or subcutaneously injected, and so this transplantation method has now been given up, and is quite obsolete: it is clear that it has no advantages over the internal administration, and very great and obvious disadvantages.

After treatment with thyroid the mental faculties are improved; the patient is brighter, less apathetic and less dull; the memory becomes better, the subcutaneous swelling diminishes, the skin changes to a softer and moister consistence, and the movements of the limbs are brisker—in short, the changes are identical with the changes which occur in sporadic cretinism, allowance being made for the age incidence of the two varieties of the disease.

The treatment, as in sporadic cretinism, consists in supplying artificially, from animal sources, the defects of the thyroid, either by hypodermic injection of a glycerin extract of sheep's thyroid, or by administering the substance internally. The latter is preferable on account of its simplicity and efficiency. To start with, one tabloid should be given three times a day, and the dose increased—at first rapidly, and afterwards more gradually.

It is quite certain, in this form of the disease, that the remedy must be continued in small doses throughout the duration of the patient's life, otherwise relapses will certainly occur, and the patient revert to his former state. One tabloid should be given about twice a week. This will generally be found sufficient to maintain the body *in statu quo*, and prevent any relapses.

With regard to operative myxœdema, it is unnecessary to say more than a few words—it is a condition practically, if not entirely, unknown in the present day. Before the absolute necessity of thyroid secretion for the performance of the bodily functions in a normal manner was recognised, surgeons frequently removed the whole of the thyroid body for goître. The result was a condition precisely resembling myxœdema. Now all operators take good care to leave a portion of the gland in the body; it may be quite a small piece—the isthmus alone is sufficient—operative myxœdema then never follows. If such a thing should occur, the treatment would, of course, be identical with that of natural myxœdema.

The next part of my subject—the treatment of some skin diseases by thyroid—has not so far received so much attention as it deserves, and I therefore particularly desire to call your attention to it. It is now just about twelve months ago since Dr. Byron Bramwell first advocated this organic extract as a remedy for psoriasis. He was led to try this, not merely as a matter of chance, but from observing the very profound and definite change which thyroid extract had on the nutrition of the skin in cases of myxœdema and sporadic cretinism, a change to which I have already referred. He noticed that thyroid extract administered for these diseases produces fine desquamation, and that the harsh, rough, dry skin of myxœdema becomes under its influence smoother, moister and softer. Why, he asked, should it not prove a useful therapeutic agent in numerous skin diseases, especially in examples of exfoliative dermatitis, such as psoriasis, squamous eczema and pityriasis rubra?

Before proceeding to deal with any special disease of the skin, I might say a few words with reference to the action of thyroid extract in health and disease. Whatever may be the functions of the gland in the human economy, it cannot be doubted that they are due to a secretion which can be separated, though, perhaps, not yet in a pure state. This is proved clearly by the fact that all the evil results of atrophy of this organ can be cured, or at least greatly improved, by a substance isolated from the gland taken as a drug. In a healthy human being it is difficult to say what the effects of large doses are, for the drug would probably cause permanent danger to the heart and nervous centres; but in moderate doses, irregular rises of temperature, slight in degree, and tachycardia, are the most prominent symptoms, the tachycardia and irregular excitability of the heart persisting for some days after the exhibition of the drug. The symptoms of poisonous doses are worthy of notice, and should be carefully watched for when the extract is used in treatment. They are briefly, rapid pulse, rises of temperature, erythema, sweating, flushings and diarrhœa; in fact, they correspond in a striking manner with the symptoms of Graves' disease.

Now as regards the method and details of administration in diseases of the skin, it has been ascertained that different individuals require very different doses of the extract to effect a cure. Undoubtedly the best method of administering the drug is to give to each individual the largest dose he can bear. Some patients can take much larger doses than others; the problem is to determine in each particular case the largest dose of thyroid extract which can be taken without upsetting the patient. It is quite certain that persons suffering from skin diseases can take larger doses than myxœdematous patients or cretins. The best guide to follow is certainly the pulse; begin with small doses and increase gradually until the pulse rate reaches 100–110 per minute. Doses larger than sufficient to cause this rate are apt to produce symptoms of slight poisoning, headache and gastro-intestinal symptoms, such as vomiting and diarrhœa. If these symptoms are produced, the dose should at once be lessened, or the remedy stopped altogether for a few days. If the pulse-rate increase is the only symptom of thyroidism, the dose need not be diminished provided that the patient feels well, has no anorexia, and his tongue is not furred, the remedy may be continued even though the pulse-rate rises above 110. The largest dose for each patient being found, it must be continued for some considerable time; in cases of psoriasis for instance, for eight weeks, in lupus still longer. Until this period has elapsed, it is not right to conclude that the treatment has been a failure. In some cases there is no improvement till distinct poisoning symptoms appear, then a rapid cure results; this is only natural, for many drugs do not produce their full therapeutical action until the physiological effects are in evidence. As to the form in which it should be given in this as in the other diseases treated by this drug, the administration of a sterilized glandular extract presents no advantage over the method of administration by the mouth, especially as rapidity of action is not wanted. By the mouth, either the fresh gland may be given or a chemical preparation of it. As

a rule, the latter seems to be preferred, mainly because it is easier to get. It is much cheaper, however, to use the fresh gland. If it is employed, it should be got from the butcher the same day as the animal is slaughtered—it may be given raw, minced up with jelly, or added to beef-tea. It is found that partially cooking the gland does not destroy its activity, therefore it may be given lightly fried. Dr. Mackenzie recommends the following method: let the gland be finely minced and allowed to stand covered with cold water for about thirty minutes. Express through muslin, and add the liquid extract thus prepared to some beef-tea.

The chemical preparations are numerous—dry or liquid. The dry are perhaps better as they keep, and can be made up in pills, powders or tabloids, of any dose required. Messrs. Burroughs, Wellcome & Co. tell me they do not make the liquid preparations of the gland, for they have found them to be decidedly unreliable: their process is to take the entire gland, a very large quantity being employed at one time to ensure a fair average, and after carefully examining them and rejecting any that are cystic or otherwise diseased, to dry them at a low temperature, about 100°F., together with some salt as a preservative; when dry, they are finely powdered and compressed into tabloids. By this means there is no question that we obtain the active principle or principles whatever they may be. Messrs. Allen and Hanbury's preparations are made in a very similar way. If a speedy cure is the object, the best treatment will be to confine the patients to bed, or at any rate to some equable temperature, to feed them on milk, fish and chicken, excluding red meats and sweets; keep the bowels regular, apply some local application, and give thyroid internally. In Dr. Bramwell's first cases of psoriasis no external application was used, as he was trying the effect of a new remedy, and this would only have complicated matters. If his observations as to the cure of the disease were correct, that is to say, if thyroid does cure psoriasis, it is only reasonable to suppose that local treatment, with established remedies in addition, will be even more beneficial.

(To be concluded.)

Appointments.

Buck, T. A., M.B. Lond., M.R.C.S., has been appointed Medical Officer on the Senior Medical Staff of the Royal Isle of Wight Infirmary and County Hospital.

Coulson, J. E., L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Medical Officer for the Infirmary of the St. George's Union.

Hinton, Hammond T., M.B., C.M. Aber., has been appointed Certifying Factory Surgeon for the Heytesbury District.

Keiffenheim-Trubridge, L. W. A., M.D. Durh., B.S., L.R.C.P. Lond., M.R.C.S., has been appointed a District Medical Officer and Medical Officer to the Workhouse of the Hoo Union.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Chrysome Children.

Dear Sir,—From Haine's Brasses I take the following:

"The child was swathed in its chrysome, and was itself termed a chrysome until it was a month old; if it died before it reached that age its chrysome served as its shroud."

"The chrysome (chrismale) was the white cloth with which infants were invested immediately after their baptism, and before they were anointed with the chrism, or baptismal oil."

See also the rubric in the "Office of Publike Baptisme," in the First Prayer Book of Edward VI.

There are several Brasses to chrysome children still existing, showing the arrangement of the garment—as at Hornsey, Middlesex, and Stoke D'Abernon, Surrey. They date generally from the first quarter of the 16th to the first quarter of the 17th century.—Yours very faithfully,

Aldershot. T. H. GIBSON.
Nov. 18th, 1894.

The Photographic Studio.

Dear Sir,—Will you allow me, through the medium of your columns, to make an enquiry as to the constitution and privileges of membership of the Photographic Studio, of which, in common with several others, I am desirous of becoming an *active* member? From the rules of the Physical Society, published in the Blue-book, it appears that six members of the Society—and presumably of the Clubs' Union—are elected to serve on the Photographic Committee, three of whom retire annually. The newly-elected members are supposed to be chosen from among those of the Society who are considered to be best qualified to make use of the Studio. My contention is that this is not altogether the case, and that, moreover, it is not entirely used for the purpose for which it was originally intended, namely, photography, as but few specimens of the committee's work are seen at the opening meeting of the Session, if, indeed, they are seen at any time. This does not seem to me to be a proper state of things, as there are others besides myself who would gladly avail ourselves of the Studio for Hospital work, and who are unable to obtain admission except by the goodwill of the existing members of the Photographic Committee.

The date of the annual election is unknown, at least to outsiders, and when casual vacancies occur, *only the nominee of the remaining members* (if there ever is one) is chosen. I venture to suggest, therefore, that due notice of the vacancies as they arise shall be posted by the Physical Society on the notice-boards, and that

members desirous of joining should send their names in writing to the secretaries of the Society. In the case of more members applying than there are vacancies for, a ballot should be taken at the next meeting of the Physical Society in which the members present shall take part.—Yours, etc., ONE WHO *IS* KEEN.

Guy's Hospital, Nov. 28th, 1894.

WE have been asked to publish the following letter, a copy of which has been sent to the Secretary of each Constituent Institution of the Clubs' Union:—

DEAR SIR,—In returning your budget I have been instructed by the Council of the Clubs' Union to forward you this letter indicating some of the points in which the Council find that the financial management of the Constituent Institutions most needs advice, and to ask you to *paste it inside the cover* of your account book for the guidance of future secretaries.

I. The budget (enclosed) should be pasted in your minute or account book, as the Council may require to see it again later.

II. The amount granted by the Council is written *across* the budget. Should you desire any further information please interview one of the Secretaries. No cheque will be drawn for your Constituent Institution until you signify in writing to the Secretary that you want the money.

III. The budget is to guide the expenditure during the forthcoming year, and if any expenditure becomes advisable which has not been anticipated in that budget, you should apply (through the Secretary of the Clubs' Union), for a supplementary grant from the Council before consenting to it.

IV. In accordance with "Rules of the Union, 10," you should prepare your balance-sheet, and get it audited as soon as possible after the close of the financial year on August 31st, and as soon as it and your budget for the ensuing year have received the formal authorization of your Committee you should forward it to the Secretary of the Clubs' Union. On page 4 of the Clubs' Union Blue Book you will see the name of the official auditors of the Constituent Institutions' accounts. Blank balance-sheet forms can be obtained in the Medical Schools. So much trouble has arisen under this head in the past that the Council have resolved to adhere to "Rules of the Union, 10," and to refuse to entertain any claim for funds unless such claim is accompanied by both the balance-sheet *and the budget*, formally authorized by the Committee of the Constituent Institution.

V. The Secretaries must give receipts for all moneys received, and must receive receipts for all moneys expended, and must show the counterparts in the first case and the receipts in the second case to the auditors.

VI. Although the balance of any Constituent Institution is usually allowed to remain in the hands of the Secretary of that Institution, yet such balance is the property of the Council of the Clubs' Union, and is liable to be called in.—See "Rules of the Union, 12."

VII. In future no money transactions on account of a dinner or of badges must appear on either side of the balance-sheet of any Constituent Institution.

VIII. Every Secretary should keep a petty cash account, and forward it to the Clubs' Union Auditors with his other receipted bills and balance-sheet and budget at the end of September.

IX. The Council request that you will draw the attention of your Committee to "Rules of the Union, 12," which provides that should the expenses of your Institution exceed the sum authorized, your Committee shall themselves be responsible for the deficit.—We are yours obediently,

ALFRED D. FRIPP, } Hon.
L. E. V. EVERY-CLAYTON, } Secs.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

W. H. D. B., WEYMOUTH.—No tubercle bacilli were recognised.

G. G. M., SALISBURY.—The gland sent showed a large increase in the connective tissue, *i.e.*, the signs of chronic inflammation with no definite tubercular deposit. The larynx definitely identifies the process as tubercular; several tubercular nodules were observed on microscopical examination.

Telegrams were sent to the following:—

1. H., CHESTER.—Klebs-Löffler bacilli in some quantity.
2. S. B., LONDON.—No Klebs-Löffler bacilli were found.
3. S., WALTHAMSTOW.—Klebs-Löffler bacilli in some quantity.
4. M., BOURNEMOUTH.—Klebs-Löffler bacilli in some quantity.

PATHOLOGIST.

List of Books recently added to the Library.

Sternberg's Bacteriology.
Malcolm Morris on Skin Diseases.
Deschanel's Natural Philosophy, 1894.

PRESENTATIONS.

By Dr. Stevenson.
Creighton's History of Epidemics in Britain from A.D. 664 to the Present Time. [Sowerby.
Johnson's Grasses of Great Britain. Illustrated by Farr's Vital Statistics.
Transactions of the Sanitary Institute, 1893.

By the Authors.
Hutton's The Vaccination Question.
Williams' (Roger) Diseases of the Breast.

BY THE UNDERMENTIONED PUBLISHERS.

Fannin & Co., Dublin.
Diseases and Deformities of the Spine. By R. L. Swan, F.R.C.S.I.

H. K. Lewis.
The Theory and Practice of Medicine. By Frederick T. Roberts, M.D., B.Sc., F.R.C.P. Ninth edition.

Cassell & Co., London.
Surgical Pathology. By A. J. Pepper, M.S., M.B., F.R.C.S.
The Students' Handbook of Surgical Operations. By Frederick Treves, F.R.C.S.

Macmillan & Co., London.
Æro-Therapeutics. By C. T. Williams, M.A., M.D., F.R.C.P.
Diphtheria: its Natural History and Prevention. By R. Thorne Thorne, C.B., M.B., F.R.C.P., F.R.S.
Inorganic Chemistry for Beginners. By Sir H. Roscoe, F.R.S., D.C.L., LL.D., M.P., and Joseph Lunt, B.Sc. (Vict.), F.C.S.
Physiology for Beginners. By M. Foster, M.A., M.D., F.R.S., and Lewis E. Shore, M.A., M.D.
Physiological Chemistry of the Animal Body. By Arthur Gamgee, M.D., F.R.S. Two vols.
Preservation of Health in India. By Sir Joseph Fayrer, K.C.S.I., M.D., F.R.S.
Primer of Hygiene. By Ernest S. Reynolds.
Public Health and Demography. By E. F. Willoughby, M.D.
Text Book of Physiology. Sixth edition: Part I., Book I. By M. Foster, M.A., M.D., LL.D., F.R.S.

Smith, Elder & Co., London.
Artificial Feeding and Food Disorders of Infants. By W. B. Cheadle, M.A., M.D., F.R.C.P.

Whittaker & Co., London.
Dictionary of Medical Terms. By John A. P. Price, B.A., M.D.
Dissections Illustrated. Parts I., II., and III. By C. Gordon Brodie, F.R.C.S.

Wright & Co., Bristol.
The Clinical Uses of Prisms and the Decencering of Prisms. By Ernest E. Maddox, M.D.
Diseases of the Upper Respiratory Tract. By P. Watson Williams, M.D.

Sport.

Rugby Football.

GUY'S 2ND XV. v. LENNOX 2ND XV.

This match was played at Honor Oak Park on November 17th, and resulted in an easy win for Guy's by 7 goals and 2 tries (41 points) to nil. We completely outplayed our opponents at every point of the game, but most of the tries were due to brilliant runs by E. Morgan. In the first half we scored 3 goals and a try: E. Morgan (2), Hicks and Tom Morgan one each, Tom Morgan kicking the goals. The second half was even more in our favour, E. Morgan scoring two more tries, Hicks, Tom Morgan and Biggs the others, Tom Morgan kicking the goals, which were all in front of the posts.

The chief features of the match were the running of E. Morgan and the place-kicking of Tom Morgan, and also a grand single-handed run by a well-known Guy's man (who turned out at the last minute for Lennox), and who, after eluding several of our forwards, was eventually collared by his own full-back! But, then, Rugby is a little confusing after Socker. Team:—

GUY'S.—H. B. Walling (back); T. Morgan, J. J. E. Biggs, W. T. Clarke and H. T. Hicks (three-quarter backs); E. Morgan and R. Mathias (half-backs); A. J. Cleveland, C. D. Edwards, N. H. Pike, J. N. Gardiner, A. H. Carter, A. H. Saward and Kinsey-Morgan (forwards).

GUY'S 2ND XV. v. MIDDLESEX WANDERERS 2ND XV.

Played at Honor Oak on Saturday, November 24th. Our opponents winning the toss, elected to play against the wind. Cleveland kicked-off. Play settled down in neutral territory, a series of scrimmages taking place. Here Guy's were superior, but the halves on receiving the ball would either not pass at all, or when they did pass, which was seldom, they passed wildly. T. Morgan at length obtained the ball, and transferred to Biggs, who passed to Barrow, who was pulled down within a yard of the line. Pressure was relieved, and their backs took up the offensive, but by dint of good defence on the part of our backs, especially Clarke, they were prevented from scoring. Our forwards playing well together, made some good rushes, and from a good dribble by Cleveland, Bagshawe picked up the ball and ran in. On the Wanderers appealing, the referee disallowed, on the ground that Bagshawe had run into touch, although the lines man did not raise his flag. Give and take play followed till half-time, when nothing had been scored on either side.

The second half was precisely similar to the first, our three-quarters making good use of the very few openings they got. Barrow had hard lines in not scoring once, but he lacked the requisite pace. Towards the end our opponents pressed and nearly got in, but Clarke relieved well. The game ended in a draw, a result which by no means represents the game.

Our halves were undoubtedly the cause of our not scoring, Morgan playing a very selfish game. Kevern passed more but was too wild. Bagshawe, Edwards, Gardiner and Cleveland were perhaps the best of a good pack of forwards. Biggs, Walling, and Clarke of the back division, playing a good game. Team:—

Guy's.—W. T. Clarke (full back); H. W. B. Walling, T. Morgan, J. J. E. Biggs, H. P. W. Barrow (three-quarters); E. Morgan, G. T. Kevern (half-backs); A. J. Cleveland, N. H. Pike, C. D. Edwards, H. V. Bagshawe, A. H. Saward, J. N. Gardiner, A. H. Carter, Kinsey Morgan (forwards). H.

Association Football.

GUY'S HOSPITAL v. GRAVESEND.

Played at Gravesend on November 17th. The ground was in splendid condition considering the amount of rain we have had lately. The game was looked forward to with great interest, chiefly because neither team had suffered defeat, also because Bart.'s had played a drawn game with Gravesend.

Guy's won the toss, and played downhill with the sun at their backs; the homesters kicked off and pressed continually, and must have scored on several occasions but for the brilliant defence of Barker and Carter; the way the latter broke up the home attack earned him much well-deserved applause. Our forwards were never on the ball once during the first half, and instead of taking their usual "ten minutes slack" extended it for the whole of the first part of the game. As it was, Guy's were lucky in being only 1 goal to the bad at half-time, the score reading Gravesend 1, Guy's 0. In the second half there was a marked improvement in our play, the forwards showing a lot of dash and good combination, and in consequence we had most of the game. This improvement enabled Palmer to equalize, after twenty minutes' play, with a magnificent shot; a few minutes' later Fitz-Hugh had the goal at his mercy, but lost a good opportunity by sending in a most feeble shot. Guy's continued to press till the call of time, but could not score, so the game remained drawn with the score standing at one all. Barker was very safe in goal, and frequently gained applause from the manner in which he saved his charge.

Of the back division Carter was the pick, and it was on account of his fine play that we managed to retain our undefeated record. Walker, in his new position of half-back, improves every match, but he must not kick so hard, and should look where he is passing. Stamford and Mandy were the pick of the forwards, who as a whole were decidedly off colour. They must learn to pass sharp and low, as by passing high the opposing half-backs invariably manage to head the ball to their own forwards. Fitz-Hugh ought to make more use of his shooting powers when in front of goal instead of passing to his wings. Palmer also is still at fault in wasting time by playing with the ball between his feet, instead of going off at once when he receives a pass.

Our best thanks are due to Dr. C. J. W. Pinching for the hospitable way in which he entertained the team at luncheon before the game, and at tea afterwards. His kindness will long be remembered by those who took part in the match. Team:—

Guy's.—M. S. Barker (goal); A. B. Carter, E. A. Longhurst (backs); A. E. Crosby, E. J. Crew, F. Walker (half-backs); L. Humphrey, R. B. Stamford, R. T. Fitz-Hugh, W. G. Palmer, P. S. Mandy (forwards).

GUY'S v. MAIDSTONE.

Played at Maidstone on November 24th, and resulted in Guy's receiving their first defeat by 3 goals to 2 (Stamford and Humphrey), after a very poor game. The play needs no description, as our team gave a most disappointing exhibition after their recent display. We must have won by a large margin but for the most feeble and erratic shooting of our front rank, Fitz-Hugh and Palmer being the chief offenders. The only redeeming feature on our side was the brilliant display of Barker and Mandy, who deserve every praise for the way in which they tried to retrieve the game.

It is only fair to add we were without our two regular backs. It is to be hoped this defeat will teach the team a lesson to play up hard the whole time.

GUY'S 2nd XI. v. BECKENHAM.

This match was played at Honor Oak on Saturday, November 24th, and resulted in a win for the visitors by two goals to nil. Beckenham won the toss, and decided to defend the goal at the pavilion end. After the kick-off, we seemed very much like scoring, pressing continuously during the first twenty minutes, but after that we dropped to pieces, and Beckenham scored their first goal from a corner kick. At half-time the score was unaltered.

Beckenham having started the ball again, play was fairly even, and after some fast play Beckenham scored an easy goal, owing to the goal-keeper not attending to the game at the time; Beckenham had a few more attempts to increase their score but were unsuccessful. The play of the forwards, with the exception of Brookhouse and Miller, was very poor, usually passing the ball behind their man instead of in front of him. The halves, with the exception of Hayes, seemed to amuse themselves with seeing how far they could kick, instead of feeding their forwards. In the backs and goal-keeper there is also room for improvement.

Births.

PENNELL.—On October 5th, at 434, Calle 25 de Mayo, Buenos Ayres, the wife of G. Herbert Pennell, M.A. Oxon., F.R.C.S. Eng., of a daughter.

RANDALL.—On November 25th, at Kildermorie, Wimbledon, the wife of Philip N. Randall, M.B., Surgeon, Royal Navy, of a daughter.

Death.

DOBINSON.—On November 17th, at Malta, Edward Miall Dobinson, Surgeon H.M.S. *Imogene*, aged 30.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette.

DECEMBER 15, 1894.

Pneumonia.

CLINICAL LECTURE BY DR. PYE-SMITH.

GENTLEMEN,—We have several cases of Pneumonia in the Clinical wards—one in a small delicate youth of 18 affected the right base, and ran a short and favourable course; another, on the left side, in a young man of 22, has not yet cleared up; a third, in a strong and temperate man of about 35, until lately serving in the Marines, began in the base of the right lung, then affected the left, which is now recovered, but dulness continues on the side where it began, probably due to empyema. I will take these cases as a text for dealing with this important and common disease, not deductively as in a systematic lecture, but analytically, taking the several symptoms as we see them at the bed-side.

First, however, we must define the disease we are speaking of. It is called *acute*, from its course, which varies from three or four days in mild cases, particularly in children, to six or seven, a very frequent period, and occasionally to nine or ten. If prolonged beyond this time the disease has either attacked the other lung, as in the case just referred to, or it has left pleuritic and usually purulent effusion as a sequela, or it is complicated by pericarditis or some other intercurrent malady.

Pneumonia is acute also in its sudden onset, usually with a rigor, but rarely, even in children, with convulsions, and still more rarely with vomiting or severe lumbago and headache. Again, it is acute in its severity, the temperature being seldom under 103°, and often one or even two degrees higher. Lastly, it is acute in its habitually abrupt termination, as we used to say, by *crisis*.

Pneumonia is called *lobar* because it affects whole districts of a lung—usually the lower lobe, sometimes only part of it, sometimes the upper lobe, and sometimes the whole of one lung with half the other. But it always affects a large patch simultaneously and almost always travels thence upwards. It is *vesicular*, because, as Addison taught, the inflammatory effusion of fibrine, blood discs, and leucocytes takes place into the air vesicles themselves, not, as was before taught, between them. It is *fibrinous* because of the nature of this exudation, a point which is intended by the corresponding German epithet "croupous."* We thus distinguish it from lobular pneumonia, catarrhal pneumonia, or pulmonary catarrh in children; from the secondary lobular but caseating pneumonia of tubercle, "the instrument of destruction in phthisis," as Addison accurately taught; from suppurative or septic and embolic lobular pneumonia in pyæmia; and from chronic interstitial pneumonia, or cirrhosis of the lung. It is probably always accompanied by the presence of the diplococcus described by Friedländer, and hence it may be regarded as a specific general infectious disease, and receive the title of pulmonary fever.

Pneumonia thus defined differs greatly in extent, severity and danger, but the symptoms and anatomy are essentially the same. The only difficulty in drawing the line is in children, between primary lobar pneumonia and confluent lobular inflammation.

Let us now take the symptoms separately. First those which are general and febrile; next those which are local and pulmonary; the physical signs we must leave perhaps for a future lecture:—

The fever, as I have said, is sharp and sudden, often reaching its highest point within twenty-four hours of the initial rigor. Such an attack is quite unlike the commonest fever of this country, enterica.

*Croup is a good English word referring to a noisy kind of breathing, and is applied clinically to a form of laryngeal dyspnœa in children which is most often due to membranous laryngitis. It is not a pathological term, and has no relation to membranes or to fibrine.

We sometimes meet with it in rheumatism, but seldom without articular pains. It frequently marks the beginning of exanthems, most frequently perhaps of scarlatina. The fever of small-pox, though equally abrupt and severe, is usually accompanied with vomiting and lumbago. In malarial fever the rigor is prolonged into a cold stage, and before the close of the day the fever is relieved by sweating.

It is not very rare for the physical signs of pneumonia to be delayed twenty-four or forty-eight hours, and perhaps even longer, after the pyrexia and general febrile symptoms have begun. In such cases there is no early pleuritic pain, and the diagnosis is often difficult; the pungent heat of the skin and the greater acceleration of breathing in proportion to the pulse will sometimes guide you aright, or an outbreak of labial herpes will give you the needful hint. I believe that in such cases the chlorides in the urine are not notably diminished, nor is albumin present, until the ordinary signs of consolidation have appeared.

Of the exanthems, in the first twenty-four hours scarlatina usually shows its character by sore throat, by great frequency of the pulse compared with respiration, and by the dry burning skin, in which last particular it agrees with pneumonia; measles by the coryza, and mumps by stiffness of the jaw, and tenderness of the parotid. In many cases, however, we must be content to wait for the appearance of the rash of an exanthem, or for the physical signs which characterize pneumonia. Erysipelas I have more than once seen produce pyrexia and constitutional disturbance for several hours, and once for nearly two days, before the red blush appeared; and a similar statement applies to quinsey. I remember one of our students coming to me, and my finding that he was going about with a temperature of 103°. I sent him, of course, to bed immediately, and on visiting him that evening could find nothing but a still higher temperature, with other febrile symptoms. The throat was quite unaffected; he had no pain in swallowing; and it was not till the evening of the second day that local symptoms of acute tonsillitis appeared. Young women are very liable to this disorder, and whether because the local pain is sometimes really slight, or because they have had it before and think less of it, or from the curious delusion by which patients often assume that a doctor knows their previous history and present feelings without being told—certain it is that they will sometimes make no mention of the throat. The only safe plan is to look at the fauces, and feel the gland at the angle of the jaw in every case. Lastly, there is influenza, which begins in the same abrupt and violent manner, and often without cough or coryza. The severe muscular pains and a headache which seems, as a good anatomist told me, to be seated exactly in his optic foramen, are symptoms that usually give warning at first, and the marked depression of strength which follows, usually decides our conclusion at last; but in many cases we must trust to negative rather than positive signs, and be content to make a retrospective diagnosis or epicrisis—that is to be wise after the event.

In most cases the mode of onset, the high temperature and quickened respiration, the flushed face, bright eyes and anxious expression, the thickly coated moist white tongue, the thick dark urine, burning skin, bounding pulse, together with the pain in the side, the short cough, and herpes on the lips, make diagnosis easy, even before we examine the chest.

But a case of pneumonia has a very different aspect when we see it on the fourth or fifth day, with history wanting or, worse still, misleading, the patient perhaps delirious, having been purged until diarrhœa has taken the place of constipation, with pleuritic and bronchitic signs confusing those of the hepatized lung, with both sides of the chest more or less affected, and possibly with pericarditis in addition. In these cases your first care must be to determine the existence of chronic disease of the heart or kidneys. Pleurisy with effusion, bronchitis and œdema of the lung are, as you know, common in the course of Bright's disease, and sometimes complicated with pneumonia. Pleurisy, both dry and serous, bronchitis and pulmonary hæmorrhage are, as you know, common in valvular disease. Next to the physical signs you must in such cases depend upon examination of the sputum. Again, pneumonia in its later stages may simulate or be simulated by three febrile diseases, which you should always remember together—enterica, tuberculosis, and pyæmia. In the absence of a well-kept chart and the presence of accidental diarrhœa, a flatulent belly, and a feeble or irregular pulse, pneumonia has a typhoid aspect. Enterica with hypostatic congestion of the lungs, with constipation, with tympanites which prevents the spleen being felt, and with only a few rose spots among the flea-bites, inflamed sebaceous glands, and sudamina of a dirty skin is sometimes hard to distinguish from pneumonia. Even a good history may tell us that the disease began abruptly like influenza; or, as in a case I saw last week, enteric fever may follow immediately upon a true attack of influenza. Pyæmia of traumatic origin can be usually reckoned for; but that from internal suppuration, from suppuration of the ear, and suppuration of the biliary passages or in the pelvis, is more often overlooked. So also is the internal septicæmia of ulcerative endocarditis, which sometimes strikingly resembles enteric fever and typhoid pneumonia. Lastly, tuberculosis, as it may simulate enterica when chiefly affecting the abdomen, so it may simulate pneumonia when chiefly affecting the lungs or the meninges. The remittent and irregular character of the pyrexia, the sputum, the sweating, and, in the case of cerebral tubercle, ptosis, strabismus, convulsions, or optic neuritis may decide in favour of tubercle; the presence of great emaciation or of bed sores is almost conclusive against that of pneumonia. It must be remembered that meningitis occasionally occurs as a complication of lobar pneumonia, but in this country I believe it to be exceedingly rare.

We now come to the symptoms of the local disease. There is always some dyspnœa, moderate when one base only is affected, urgent in double pneumonia, and it is usually orthopnœic, with very rapid breathing, out of proportion to the pulse.

In the beginning of the disease, the breathing is frequent because it is shallow, and shallow because it is painful, owing to the pleurisy, which is the earliest and constant complication of pneumonia. Cyanosis belongs to the later stages and most severe cases. The accession of severe dyspnœa with orthopnœa and distress is sometimes indicative of acute pericarditis—a frequent and usually fatal complication of double pneumonia.

The cough of pneumonia is short, dry, and painful; it is, in fact, a pleuritic cough. Afterwards it chiefly depends on the amount of bronchitis, and there may be pneumonia without any cough at all.

The sputum is very characteristic, scanty, tenacious, and rusty from the presence of blood. Occasionally I have seen pure blood expectorated, and the patients have made a good recovery. Of the various constituents which make up sputum, there is little mucus and no pus. When thinner than usual, the rusty sputum has been compared to prune-juice. The colour varies from bright golden yellow, through orange and burnt sienna to bright red, or dark russet brown. Occasionally it is green, from some change in hæmoglobin, and this is an unfavourable symptom.

Pneumonia of the apex is comparatively rare, but more commonly met with in children than in adults. The symptoms are like that of the basal affection and it never, I believe, leads to phthisis. In fact, although pneumonia does not protect from a recurrence, recovery is usually prompt and uncomplicated. Almost the only frequent sequel is empyema. When you find that after the temperature has fallen it rises again and dulness continues at one base, with weakness or absence of breathing and loss of vocal fremitus, you may be almost sure that there is pus in the pleura. One of our cases, No. 16 in John, has since exemplified this. In another case, No. 10 in the same ward, similar symptoms made us suppose a similar condition, but here the hypodermic needle failed to extract fluid. In this case there is probably slower absorption than usual of the exudation in the inflamed lung. It will, I have little doubt, clear up satisfactorily. There are a few cases on record in which pneumonic consolidation has continued indefinitely, and ended in chronic cirrhosis of the lung.

Lastly, pneumonia occasionally, but very rarely, ends in gangrene. Abscess used to be described as an occasional result, but I believe wrongly; such cases are really circumscribed empyæma. The lobular pneumonia of pyæmia always suppurates, but the abscesses are small and numerous, and no pus appears in the sputum. The lobular pneumonia or pulmonary catarrh of children often ends in caseous degeneration and phthisis; but I believe this is never the case with lobar pneumonia.

Prognosis.—This depends first on the age of the patient. In children and young adults single pneumonia always does well, and even double pneumonia very often. In men above sixty the same disease is very serious, and if it affects both lungs is most commonly fatal. The next point is the condition of the patient's organs. A patient with valvular disease is seriously handicapped when attacked by pneumonia. Still more serious is the forecast for one with chronic Bright's disease, and pneumonia in drunkards is commonly fatal. On the other hand, I have seen phthisical patients go through an attack of acute pneumonia and recover.

Next to the extent of lung involved, pericarditis is a most serious complication. The empyæma of which I spoke ought to recover if recognised and properly treated. A high temperature is less serious than very rapid breathing, and that again than a frequent, weak, and irregular pulse.

Treatment.—We have no means of checking the progress of hepatization, we can only guide the patient through the attack. To relieve the pain of pleurisy, we may use hot poultices, hot-water bags, or bladders of ice, whichever is most agreeable to the patient, or we may put on three or four leeches over the painful spot, or inject morphia under the skin. Cold or tepid sponging is almost always grateful, and if the temperature rises above 104°, an ice pack or a cool bath is indicated. Do not give stimulants to young and healthy subjects until they are required, but they always are required in treating the pneumonia of elderly people, and must often be given very freely. Let the patient drink as much cold water as he likes, and feed him with milk, beef-tea or meat-jelly, and egg and brandy mixture. When the breathing is much affected, ammonia is the drug upon which we rely, and its benefit is very striking. When the pulse is weak, rapid and irregular, one naturally orders digitalis, and I believe I have seen it useful, but it more often disappoints one, and if it does not strengthen and slow the pulse is probably better omitted. A more useful medicine in pneumonia is strychnia, given by the mouth, or, in urgent conditions, subcutaneously. A few grains of calomel are perhaps the best aperient to give when required, especially at the outset of the disease, but the repeated administration of mercury is either useless or injurious. A grain of opium, or ten grains of Dover's powder, are often invaluable to procure sleep, and need never be withheld unless there is cyanosis or previous disease of the kidneys.

In cases of great exhaustion, I have sometimes given the old-fashioned and almost forgotten musk, in ten grain doses. It is very expensive, and is far from always successful; but I feel sure I have seen it save life in pneumonia and enteric fever.

As soon as the temperature falls, the patient is usually convalescent and appetite returns. He may eat what he pleases, and if needful his appetite may be assisted with quinine. If brandy has been previously taken it should now be omitted, and wine or beer be taken as a beverage instead.

Erosion of the Teeth.

Notes from a Lecture by Mr. Newland-Pedley.

Definition.—A superficial wasting of the tooth commencing in the enamel, extending to the dentine, and resulting in the formation of shallow ("saucer-shaped") cavities with a hard, polished surface.

The favourite site of erosion is the labial surface of the central and lateral incisors in the upper jaw. In some cases the cavity deepens until the crown of the tooth is separated from the root; in other instances the polished surface becomes affected by ordinary caries. Diagnosis from ordinary caries:—

Erosion.

Affects enamel chiefly.
Rarely forms undercut cavities.
Hard, polished surface.
No pigmentation.
Attacks labial surfaces.

Caries.

Affects dentine chiefly.
Generally forms undercut cavities.
Soft, irregular surface.
Pigmentation.
Attacks fissures and interstitial surfaces.

Microscopically.—

Dentinal tubes terminate abruptly.
Surface free from decalcification.
Enamel of affected area shows structural defects, being granular and more easily acted on by acids than well-formed tissue (Underwood).

Causes.—Evidence chiefly negative.

(*a*). Not absorption. Occurs in some positions quite sheltered from contact with soft tissues.

(*b*). Not abrasion from tooth-brush or tooth-pick.

(i.) Seen in the mouths of patients who do not use either.

(ii.) Observed in the teeth of some seals.

Coleman remarks that some seals take stones, sand and gritty substances into the mouth.

(*c*). Associated with bone disease and imperfectly developed teeth (Sutton).

Several instances have been recorded in which erosion has attacked natural teeth worn on dentures, and in at least one of these cases the patient rarely brushed his teeth.

Dr. Black produced similar appearances in teeth removed from the mouth by means of a continuous current of dilute HCl (1—400).

Allied to erosion is a wasting of the enamel covering the whole crown of a front tooth; also a shortening of the cutting edges of front teeth, producing a wide space between the upper and lower teeth when the mouth is closed. Tomes cites a case in which three-eighths of an inch separation occurred in two years.

Treatment.—Soft tooth-brush, alkali tooth-powder. If the surfaces are painful, apply nitrate of silver in back teeth and chloride of zinc in front teeth. Fill suitable cavities.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	4, 41, 42, 46.	Chlorosis.
	7, 16.	Ulcerative endocarditis.
	49.	Mitral stenosis and regurgitation.
Philip	2.	? Aneurysm. Hæmoptysis. Dysphagia.
	16.	Aortic regurgitation.
	28.	Tricuspid regurgitation. Emphysema. Glycosuria.
	36.	Mitral regurgitation, and ? aortic stenosis.
Stephen	13.	Aortic stenosis.
	16.	Mitral regurgitation. Aortic stenosis.
	18.	Mitral stenosis. Hemiplegia.
	25.	Mitral stenosis and regurgitation. Aortic regurgitation.

Nervous System.

Mary	3, 5, 6, 33, 35, 47.	Chorea.
	39.	Locomotor ataxy.
Philip	4.	Pain and wasting of extensors of left thigh.
	5.	Malarial neuritis.
	8.	Cerebral syphilis. Amnesia.
	14.	? Cerebellar tumour.
	18.	Pain in back. ? Cause.
	29.	Right hemiplegia and aphasia.
	30.	Hydrocephalus following injury.
Stephen.	10.	Sciatica.
	12.	Cerebral tumour. Optic atrophy.
	17.	Spastic paraplegia. Myelitis.

Alimentary System and Abdomen.

Mary	9.	Abdominal tumour. ? Nature.
	13.	Ascites. ? Cause.
	19.	Gastric ulcer.
	30.	Carcinoma of stomach. Moveable kidney.
	38.	Stricture of œsophagus.
	48.	Abdominal pain. ? Cause.
Philip	15.	Gall-stones.
	17.	Ascites. Pleuritic effusion.
	24.	Ascites. Cirrhosis of liver.
	31.	Dysentery.
Stephen	3, 5.	Cirrhosis of liver.
	39.	Carcinoma of stomach.

Typhoid Fever.

Mary	8, 11, 20, 32, 37, 50.
Philip	3, 6, 7, 37.
Stephen	2, 19, 24, 28, 34.

Genito-Urinary System.

Mary	10.	Chronic tubal nephritis.
	22.	Chronic interstitial nephritis. Hypertrophied and dilated heart.
	33.	Diabetes mellitus.
Philip	11, 21.	Diabetes mellitus.
	22.	Chronic tubal nephritis.
	26.	Renal colic.
	38.	Chronic tubal nephritis.
Stephen	11, 15.	Diabetes mellitus.
	29.	Renal calculus.

Respiratory System.

Mary.	36.	Pleuritic effusion.
	44.	Pneumonia.
Philip	23.	Bronchitis and emphysema.
	32.	Pleuritic effusion.
Stephen	14.	Empyema.
	20.	Hæmoptysis. Phthisis.
	27.	Chronic laryngitis.

Phthisis.

Mary	17, 28.
Philip	21.
Stephen	4, 15.

Miscellaneous.

Mary	23.	Osteo-arthritis.
Philip	9.	Influenza.
	34.	Tertiary syphilide.
	39.	General œdema. ? Cause.
Stephen	5.	Syphilis.
	7.	Caries of spine. Pleurisy.
	8.	Tuberculous joints. Anæmia.

Acute Rheumatism.

Mary	27.
Philip	25, 27, 33.
Stephen	22, 30.

Cases under Dr. Taylor.

Stephen.

13. T. D., æt. 41, a schoolmaster. Admitted December 3rd for "recurring weakness and fainting fits."

Previous history.—Patient had rheumatic fever when eleven, since then has had occasional attacks of dimness of sight, which were preceded by some premonitory sensation, as that he "knew he was going to have an attack," and were followed by headache. Otherwise he has been quite well and followed his employment up to July last.

Present illness.—Last winter he had more headache than usual. In January last he had a fainting fit in school. In March had a similar one and fell down in the road. In May fits got more frequent, and by July he had two or three of these attacks in a week, and a little later sometimes two or three in a day. He stayed in bed six weeks, then got up every day and rested a good deal. During the last week in September he had a similar attack and another a week later. He commenced work again in October, but was ordered by doctor to give up immediately. He could only walk very slowly. Has since stayed at home and kept his bed entirely for the last month.

On admission.—Patient is a stout man, with florid complexion and slight yellowish tinge; seems comfortable and free from distress. No œdema. No dyspnœa. Left side of chest somewhat bulged over third and fourth left intercostal spaces near sternum. Few râles at both bases behind. Pulse 36, with distinctly palpable anacrotic wave, as verified by sphygmograhic tracing, which shows long diastolic fall of arterial tension, regular. Impulse in sixth space, just outside nipple. Systolic thrill in aortic area. Cardiac dulness bounded above by third rib, internally by line midway between middle line and left border of sternum, externally by line drawn from nipple to point of impulse. At impulse is heard a blowing systolic murmur, traceable into axilla, and heard behind at left of left scapula; occasional doubling of second sound at impulse. In aortic area, systolic bruit louder and rougher than over any other part of chest. All over front of chest and cardiac area the first sound is replaced by a systolic bruit. Several observers at different times have detected a mid-diastolic sound at left of ensiform cartilage, and also at other parts of chest, which is certainly not constant, and of doubtful importance. Liver can be felt one inch below costal margin and pulsates distinctly. Urine contains no albumin. Mist. Ammonii was prescribed, but pulse still remains from 32 to 38 in rate. Patient seems fairly well while resting. Dr. Taylor thought there was aortic stenosis and tricuspid regurgitation and probably some mitral stenosis and regurgitation. The most important lesion, however, is aortic stenosis.

Mary.

39. E. B., æt. 32. Admitted December 4th for "pains, inability to walk, and vomiting."

Previous history.—Good health until fourteen years old, when she had an attack of acute rheumatism (?). When eighteen she had sore places on feet, between toes, which emitted a very offensive odour, and simultaneously mouth was very raw and tender. Otherwise well up to date of marriage, six years ago. Had one child born at seventh month, which lived only 38 hours; several miscarriages since. Five years ago right eye became painful, intolerant of light, and patient was unable to see with it; almost complete recovery of sight in a year, after treatment. Four and a half years ago she had attacks of pain after food and vomiting; also diplopia, one image appearing as red and the other yellow. Three years ago red, annular, itching rash on abdomen and legs, which disappeared with treatment. In May, 1893, she was admitted, under Dr. Taylor, for "pain in back and stomach, and periodical attacks of sickness"; symptoms first seemed to point to dyspepsia, but on making further enquiries and examination, it was found that she had been treated by Dr. Horrocks for syphilis. Pupils

reacted slightly to accommodation, but not to light. Bilateral ptosis most marked on right side. Slight loss of power in legs. Knee-jerks and plantar reflexes absent. Sensation normal. Shooting pains in legs, and occasionally in arms. Inability to stand steady with feet close together and eyes shut. She was discharged with sickness much better, but pains fairly frequent. Since then, attacks of vomiting have been getting less frequent, and generally start with shooting pains in limbs and groins, followed by involuntary passage of urine, diarrhœa, and pains in chest. Vomit greenish. Power of walking has been gradually getting worse until now, when she is unable to walk without assistance.

On admission.—Eyes:—Right eye diverges somewhat after patient looks at an object in front of her for some time. Neither pupils react to light, and only the left one slightly to accommodation. Discs and fundi normal. Band of anæsthesia round trunk at level of nipple. Impairment of sensation at outer part of right thigh and dorsum of right foot. Heat and cold sensations normal. Numbness of left middle finger and gluteal region. Sense of constriction round thigh. When standing patient feels as if treading on sponge. Slight loss of power in flexors of leg, especially the right. Slight inco-ordination of movements of left upper extremity. Ataxy very marked—patient in walking throws feet forwards and then brings heels down forcibly. Knee-jerks and plantar reflexes absent. *Abdomen:*—There is slight pulsation of aorta above and to left of umbilicus. Urine is acid and contains no albumin.

Diagnosis: "Locomotor Ataxy."

Mist. Pot. Iodid. was prescribed; patient has had several attacks of vomiting with pain and incontinence of urine since admission.

The chief interest in this case lies in the fact that she was first admitted into Guy's as a gastric case, locomotor ataxy not being suspected until a systematic examination had been made, and Argyle Robertson pupils and absent knee-jerks discovered.

In the Surgical Wards.

Cases under Mr. Howse.

Accident	22.	Ruptured urethra.
Naaman	7.	Pulpy knee.
	17.	Enlarged thyroid. Two previous operations for removal of right lobe. ? Carcinomatous change.

Cases under Mr. Davies-Colley.

Lydia	1.	Abscess of breast.
	8.	Carcinoma of both breasts. Amputation of one breast.
	9.	Non-union of jaw after fracture and wiring, &c.
	21.	Strangulated femoral hernia.
Cot.		Hip-joint disease. Abscess.
Luke	4.	Hydrocele of cord.
	6.	Hammer toe. Excision of head of proximal phalanx.
	9.	Swelling lower end of humerus. ? Syphilitic osteitis, sarcoma, &c.

Cases under Mr. Lucas.

Accident	9.	Fractured femur.
	9.	Upper jaw displaced by blow.
	19.	Ruptured varicose vein.
	31.	Run over abdomen. Injury to kidney. Hæmaturia.
Lydia	13.	Lumbar abscess.
Job	7.	Flat foot.
	7.	Otorrhœa. Mastoid abscess. Antrectomy.
	9.	Traumatic stricture. Retention.
	19.	Syphilitic testicle. Gumma.
	21.	Mastoid abscess. Antrectomy.
	25.	Swelling lower end of femur. ? Sarcoma or syphilitic osteitis.
Charity	22.	Stricture of anus following excision of rectum for carcinoma in a young woman of 22.

Cases under Mr. Golding-Bird.

Martha	1.	Hip disease.
	3.	Carcinoma recti. Excision of rectum.
Lazarus	7.	Ulceration of rectum. ? Tubercular.

Cases under Mr. Symonds.

Martha	13.	Involution cysts in breast. Removal.
	15.	Goître. Removal of lobe.
Luke	17.	Semilunar cartilage detached from its peripheral attachments. Removal.

Case under Mr. Lane.

Patience	5.	Carbuncle on back of neck. Incision and scraping. Sulphur applied.

Case under Mr. Jacobson.—Clinical P. R. Prostatectomy.

A. J., coachman, æt. 60. *Family and previous history* good. First had difficulty in passing his urine five years ago, which ceased on using catheter once or twice; during three subsequent years only had few occasions to use catheter, but this became a daily necessity about twelve months ago, sharp and severe shooting pains from glans along penis making their appearance; during this month condition was gradually getting worse.

Condition on admission.—Patient in a state of great pain and misery; an increased dragging pain being felt just before an attempt to pass urine. During the night micturition was as frequent as four times an hour; about half as frequent during the day. The stream consisted of a few drops at a time dripping from end of penis, which was not improved by straining of patient; "residual urine" amounted to 7 ounces; stream through the catheter was good. The urine was acid, sweet, and

sp. gr. 1015, 1·8 per cent. urea, ·4 per cent. albumin; had history of blood, but none found after admission; no casts. Examined per rectum, prostate found enlarged and indurated; no heat and tenderness about rectum. Catheter in its passage hitched in situation of prostate; on depressing it well, passed safely and easily into bladder.

Operation.—Ether was administered, a superficial incision was made, 5 inches in length, from below umbilicus to symphysis pubes; low descent of peritoneum allowing but very little working room, this was reflected a little higher. The bladder, which had been previously distended, was brought up to surface of wound, and an incision 1¼ inch long was made into it. On exploration with finger, Mr. Jacobson found and removed a stone, 1¾ by 1 inch, weighing 236 grains. The median lobe was found to be distinctly enlarged, and by means of a Jessop's forceps and enucleation with the finger, 141 grains of growth were removed. To stop bleeding, which was at no time sufficient to cause any anxiety, Perchloride of Mercury solution, 1 in 2000, was injected three times during operation. Upper two-thirds of wound was then sutured with stout silk sutures, the lower one-third being left open for a Thompson's tube to drain bladder, the wound in which was stitched to the sides of the superficial wound. *Patient took anæsthetic well. Patient went on well* after the operation. His temperature rose to 101 the first day, but since has not been over 100. There was never any hæmorrhage. The bladder is still draining superapubically, though wound is quite small now and granulating well. A full sized catheter is passed easily. Patient has been sitting up for some days. P. H.

Case for Diagnosis.

(By kind permission of Dr. Lancaster.)

D. S., æt. 44, Pedlar, admitted for muscular incoordination.

Family history.—Father, a sea-captain, died by accident at 56. Mother died at 49; had twenty-seven children—twins four times. No history of any neurosis in any members of the family. Patient is the third child. All patient's brothers and sisters younger than himself have died at various ages, from 4 to 34. Patient says some of them died of fevers; no further particulars.

Previous history.—Patient had a severe attack of scarlatina when nine years old. After this he was subject to fits, which came on suddenly and without warning—sometimes he had two in a day, sometimes he went a week without any. The fits used to last half-an-hour; they were accompanied by absolute unconsciousness, clenching of hands and teeth and struggling, the head being turned to one side or the other. Patient used to fall and hurt himself. No defæcation or micturition. Fits ceased when patient was seventeen and have never returned. Speech has been affected ever since. No fall or accident.

Present condition.—Patient is a healthy-looking man. No loss of sensation anywhere. Reflexes:—Knee-jerks increased; no ankle clonus. Wrist and triceps-jerks present on both sides. Optic discs normal. Both sterno-mastoids and platysmæ contract, the left more than the right, the chin being thrown to the opposite side, and the face assuming the most grotesque contortions. The speech is slow, laboured, accentuated, and yet blurred. Patient much better than he was twenty years ago. He can walk twenty miles a day, better at the end than the beginning. Patient is very intelligent. A great irregular tremor in arms and legs when patient makes any attempt at using them. The whole left side is weaker than the right; left grip about half right; no reaction of degeneration. Patient can feed and dress himself, but with considerable difficulty. The tremors resemble those of disseminated sclerosis. He has improved a great deal in the eight weeks he has been in. He occasionally complains of great pain in left hypochondriac region, which is relieved by Bismuth, and seems to be due to gastritis.

The case is very peculiar, and the nearest diagnosis is that it is a post-epileptic condition. Can any of your readers offer a solution?

S. G. FLOYD.

Rare Cases of Diphtheria.

1. Child was vaccinated. On the tenth day a diphtheritic patch over the vesicles, about the size of a crown. All the family had sore throats, with gluey mucus. The drains were found defective.

2. Child had diphtheritic membrane within and around vagina, and on the groins; also in the axilla. Sore throats in the house, and defective drains.

In these cases little if any constitutional symptoms.

Treatment.—Iron internally, and iodoform and boracic acid powder as an application. Both cases doing well.

WALTER BUCHANAN, M.R.C.S.E., &c.

Paddock House, Chatham,
15th November, 1894.

Notice of Course of Lectures.

A course on the Special Senses and Central Nervous System will be given in the Physiological Laboratory of University College during the Easter Term, on Tuesdays and Thursdays, from 2 to 4 p.m., commencing on Tuesday, January 15th. The course will be conducted by Mr. L. E. Hill, M.B., Assistant Professor of Physiology, to whom the names of those who purpose attending the course should be sent in.

The fee will be four guineas.

J. M. HORSBURGH, M.A.
Secretary.

A Case of Follicular Odontome, or Dentigerous Cyst.

By JOHN W. PARE, M.D., C.M. Edin., L.D.S. Eng.

Mary J., æt. 17, a weakly-looking girl, was advised by Mr. G. S. Bell, surgeon, of Leytonstone, to consult me about a swelling in the upper jaw causing some disfigurement, and also with reference to a carious tooth upon the same side which caused pain. The patient stated that the swelling was first noticed about twelve or fifteen months ago, and since then it had slowly grown to its present size, viz., that of a walnut, without giving rise to pain or much inconvenience.

On examination, there was found to be a very hard swelling filling the buccal sulcus, near the left canine eminence. The swelling was not the usual globular one, because a prominent sharp ridge was felt, running downwards and forwards across its centre towards the mesial line. The left upper canine was missing, and was said never to have been erupted; also there was sufficient space for it between the lateral incision and the first bicuspid. The premolar being carious, loose and tender on percussion, with an injected red line round the gum margin, was extracted, but its socket did not communicate with the swelling; there was no crackling nor crepitus felt; the alveolar border and the teeth maintained their normal relative positions.

A diagnosis of dentigerous cyst being made, and the case being more suitable for hospital treatment, Mr. Maggs kindly consented to take the patient under his care at Guy's Hospital. On the 31st May, 1894, the patient being anæsthetised, Mr. Maggs opened the buccal wall of the swelling with bone gouges, and about a drachm of yellowish glairy fluid, showing masses of cholesterin, escaped. On probing the cavity the characteristic sound of enamel indicated the presence of a tooth, which latter was directed outwards, downwards and forwards, the crown pointing to the alveolar border. The tooth was firmly implanted, and on the forceps being applied some force was required to dislodge it; the walls were then squeezed together, and the cavity packed with carbolized lint. The patient attended the hospital weekly to have the cavity syringed with a solution of chloride of zinc and for observation, meanwhile syringing the cavity herself with the same lotion. The swelling, which was not in communication with the antrum, subsided slowly, and in October had disappeared.

The tooth was a well-formed left upper canine, with fully developed root. It had the appearance of being recently erupted, the enamel being chalky, not translucent. It was placed in a 30 per cent. solution of rectified spirit, to preserve it for examination. It was next embedded in melted wax, in such a way that half the crown and root were exposed. The latter was then subjected to the action of a 10 per cent. solution of hydrochloric acid. After a short interval, bubbles were seen to arise, and the enamel to assume a more chalky and opaque appearance. On scratching it, a white powder was removed, leaving unaffected the enamel beneath, and this in turn was similarly acted upon by the acid. *No Nasmyth's membrane was seen.*

On examining microscopically the white powder, it was seen to consist of enamel prisms. On removing the tooth from the wax, it was found that the covered portion was unaffected by the acid. The object of placing it in the wax was that if Nasmyth's membrane were present, it could still be shown *in situ* attached to the tooth at the unaffected part.

It may be mentioned that there is often seen a little swelling, containing fluid, over the crowns of erupting teeth before the gum is cut. Sir John Tomes, in his "Dental Surgery," puts forward the theory that if this fluid, which he supposes to be between the tooth and tooth-capsule, were enormously secreted, and the tooth never erupted, then a dentigerous or follicular cyst would result, and if so, no Nasmyth's membrane would be found over the crown.

The interest attached to this case is that no Nasmyth's membrane was found upon a careful and minute examination of the tooth, and the tooth itself, both as regards the crown and root, was normal in appearance and development. Mr. Bland Sutton says: "The cavity of the cyst usually contains viscid fluid and the crown or the root of an imperfectly developed tooth."

In conclusion, I desire to acknowledge the assistance I have received from my friend, Mr. Herbert Wallis, both as regards the notes of the case and the after examination of the specimen.

Portland Place, W.

Personal Reminiscences of Diphtheritic Paralysis.

In February, 1892, I suffered from a moderately severe attack of diphtheria, with an extensive formation of membrane on the fauces, and some symptoms of extension to the nose. The membrane was first seen on January 30th, and on the following day I was warded, remaining in hospital till the end of February.

The first sign of paralysis that I noticed was early in the fifth week while taking afternoon tea. The fluid suddenly seemed to take an extraordinary course, producing a peculiar feeling which I have not felt at any other time; but I believe what happened was that some of the tea entered my naso-pharynx, causing reflexly uncontrollable eructation from the stomach. A day or two later I first noticed that, after reading a little time, words would become misty and indistinct. These two paralyses, faucial and ocular, were all from which I suffered until the end of March.

The difficulty of swallowing did not much increase. I found that rapid drinking would cause a little fluid to trickle through the nose, but with a little care I could always avoid this. But all fluids were not alike, and

I found more difficulty with port wine than with the rest of my dietary, as it was more apt to start the reflex before mentioned. My voice soon began to be affected; certain words becoming difficult to pronounce, so that I had sometimes a difficulty in making myself understood.

I had been taught that the letter *K* was the shiboleth of diphtheritic patients, but I did not find it so in my case, being able to enunciate clearly such words as *kicking*. My difficulty lay with the labials, owing to inability to completely close the posterior nares. Just at the end of March I took my qualification, and I remember being constantly asked by everyone what degree I had taken, to which I could only reply, "Em me, me see," instead of M.B., B.C. It will thus be seen that I really "talked through the nose" in contrast to a patient with nasal catarrh, who is quite unable to do so, although the phrase is usually used to describe his voice; and I had even more difficulty with words such as *and*, where a labial follows a nasal, pronouncing them as *an* with an extra emphasis, which was the only approach I could make to the double consonant. At first I found that deliberation and determination would effect a correct utterance, but after a week or so neither of these had power to bring about this result.

As to my eyes, I found it best to read with spectacles about 1. D., especially if not in a good light, but never progressed further. My pupils were usually unequal, but I could never discover any difference in the sight of the two eyes. The affection, such as it was, was more a fatigue effect than a constant diminution of power, and hence defied measurement.

During March I went into the country, and quickly regained what little strength I had lost during my illness. I used to walk about six miles a day, and indulged freely in boating and swimming. I had one symptom that would now cause me some anxiety should a patient of mine be in the same case—viz., an irregular pulse; but at the time, possibly from ignorance, I did not worry about it. I discovered it accidentally, and since I found that after a long walk, or after pulling a canoe over a dam, my pulse was quite regular, but on the other hand, when I lay down and felt my pulse carefully, it appeared to beat once or twice and then wait to see if it could outwait my patience. I therefore concluded that the observation of my own pulse-rate was unprofitable, if not risky, and gave up the practice.

During the last week in March, when my ocular and faucial symptoms were steadily subsiding, a friend discovered that I had no knee-jerk. At first, after getting up, I had tested my jerks daily with interest, but after a time I tired of the amusement, so I cannot tell when the jerks first vanished. On April 1st, I commenced duty as House Physician, not feeling any further symptoms, and the former ones having all but cleared up. But very soon paralysis appeared in my arms and legs, so gradually that I can fix no date. The first sign was numbness in the tips of the fingers and toes, I cannot remember which preceded, I think the lower extremity, but the two were almost simultaneous. The march of symptoms was gradual and uniform, from this time till about the end of May. At first I found it impossible to hurry when walking, though I did not mind walking several miles; later on a feeling of fatigue generally restricted my walk to less than a mile, though I have no doubt I could have gone further. Walking upstairs became very difficult if using my legs alone, and I usually did most of the work by pulling on the banisters with my arm. Any attempt to run caused an irregular spasm of the leg muscles. My gait was rather unsteady, and I found it difficult to walk straight, but much more so to turn round, in doing which I used always, if possible, to steady myself with my hands. I found myself rather more unsteady after dark, also if I thought I was being observed; I particularly remember what an ordeal it was to walk past Dr. Goodhart, under whose treatment I was. On the other hand, I had no difficulty in standing steady with my eyes shut.

In my hands the sensory disturbance was more of an inconvenience than the motor, though both combined to cause a certain clumsiness and helplessness, exactly as takes place from exposure to cold, when one can hardly make out whether it is loss of power or loss of sensation that makes one quite unable to turn a stiff key or get a button through a buttonhole. The tips of the fingers were most affected, but the hand and forearm to a much less extent. I cannot compare the feeling to anything better than the numbness of cold; the next best comparison is to feeling objects through a sheet of paper, or (not so good) through a glove. I wrote slowly and shakily. For many weeks I was unable to feel the pulse of more than half my patients, and was forced to count the rate through a stethoscope. I always had a difficulty to do up buttons while dressing, especially behind my back, and it was a matter of wonder to me every day how my collar got on, as I was unable to tell by feel the steps of the process. Once, just at the climax of the complaint, I tried to put on dress clothes, and owing to the extra stiffness of the buttons failed entirely, and had to be dressed by a friend. My power of grasp, as measured by a dynamometer, fell from about 90 to below 30.

My feet were as numb as my hands, though the loss of sensation in the former did not trouble me so much. I noticed a greatly increased tendency to feelings of "pins and needles" from a constrained posture causing pressure on the nerves, which sensations, though easily produced in health, were still more readily produced and much more persistent when I had peripheral neuritis.

In contrast to the slow progress of these symptoms, the recovery was almost sudden. About the last week of May, *i.e.*, seventeen weeks from the initial illness the symptoms were still progressing, but in the following week I felt much more power over my legs, and one day I ran up the whole set of stairs in the medical building. I cannot now remember how long the last traces of paralysis took to disappear.

As to treatment, I took *Liq. Strych. Hydrochlor.* ɱx. t.d.s. for some weeks in March, leaving it off when the ocular

paralysis was nearly gone. In April, when the limbs began to be attacked, I resumed it for many weeks, but since the paralysis steadily progressed I left it off again. The progress continued some time after that, and, as far as I can judge, the drug had no influence at all. The details I have here brought together may appear rather trivial, but owing to the majority of sufferers from this disease being children, many symptoms may often escape notice. For instance, the predominance of the sensory over the motor symptoms could hardly be established in case of a child, and hence has not been emphasized in text-books.

Tottenham. F. M. TURNER.

Guy's Hospital Debating Society.

The Debating Society met on December 1st, to discuss the Gothenburg Public-house System. It was unfortunate, considering what a hazy notion most people seem to have of this system, that the inclemency of the weather kept so many of the members of the Society at home on the evening it was to be considered. In the account of the last meeting the Gazette's reporter was obliged ("*quia carent vate sacro*") to celebrate the performances of the speakers in verse; but on this occasion he is saved the trouble of wooing the coy Muse, as it is a remarkable fact that the cause of temperance breeds poets where one would least expect them, and from Sir Wilfred Lawson downwards, one seldom hears an oration on the drink question unadorned by an original effusion in verse.

In the absence of the Vice-Presidents, Mr. Dunn kindly consented to take the chair, and though the meeting, as has been observed, was small, there was no lack of speakers, at any rate on one side of the House.

Mr. Carden, in bringing forward the motion, gave a short account of the conditions which led to the experiment in Christiania in 1865. He said that drunkenness being then very prevalent, a company was started who were to run improved public-houses, with a fixed interest to shareholders of six per cent. This produced a great reduction in the consumption of spirits, and also in convictions for drunkenness and cases of delirium tremens. In 1876 the operations of the company were extended to the retail trade, with marked advantage to the cause of temperance. Mr. Carden then laid upon the table copies of the Liquor Traffic (Local Control) Bill, and the Licensing Laws Amendment Bill. Going on to speak of Mr. Chamberlain's and the Bishop of Chester's schemes, he pronounced distinctly in favour of the latter, which gives control of public-houses to a company and not to the local authority; having been accused formerly, he said, of being a poet, he would conclude with the following verses:—

If swift and strong the current flows,
It will not be stopped by sudden blows.
'Tis better to regulate supply,
And thus a potent remedy apply.
A nation cannot be sober made,
By local veto or lemonade:
Let the output of alcohol be less,
And extricate us from a terrible mess.

Mr. Reaside, in rising to oppose the motion, began with apologies for want of knowledge of the subject and want of time to prepare his speech. The attention with which the House followed his remarks must, we think, have convinced him that this was unnecessary. He dwelt upon the impossibilities of introducing continental methods into Great Britain, where individual persuasion went further than any Act of Parliament could in correcting abuses. He instanced the officialism of railway servants on the Continent and declared that it would never be tolerated here. He then pointed out that exceptional circumstances had led up to the adoption of this system in Sweden, which did not now exist in England. Going on to criticise the three possible systems in detail, he declared that the question of how to apply profits was the crucial one in each, and that the complexity of the arrangements and the difficulty of working any of these systems would always be an efficient bar to their introduction into this country. He also considered that proprietors were always more likely to work a concern well than mere paid managers, and that with the abolition of competition, deterioration of the trade would set in. He finally reiterated his plea that the drink question was one for private influence and not for State policy.

The following gentlemen took part in the debate which followed:—Mr. Hardy, Mr. Nourse, Mr. Hamblin Smith, who spoke on behalf of the "moderate drinker," who (he contended) would be damaged by the introduction of a Gothenburg system; Mr. Biggs, who did *not* speak on behalf of the "moderate drinker," but was nevertheless strongly opposed to the motion; Mr. Anderson, and Mr. Croucher, who capped the hon. proposer's verses with the following:—

"Ah! Mr. Carden, you're wrong I declare,
I fear by this time you are tearing your hair;
For Mr. Reaside with his caustic remarks
Has made ducks and drakes of your Gothenburg larks."

The sole speaker in support of the motion was Surgeon Bett, R.N. Under the circumstances, the proposer was perhaps wise in not pressing for a division.

The motion was accordingly declared lost, and a hearty vote of thanks to Mr. Dunn terminated the proceedings.

Acknowledgments.

St. Bartholomew's Hospital Journal.
St. George's Hospital Gazette.
St. Thomas's Hospital Gazette.
The London Hospital Gazette.
The Cambridge Review.
The Hospital.
The Medical Pioneer.

Passim.

It affords us the most genuine satisfaction to join in the gratification expressed on all sides at the distinction the Guy's candidates have but lately achieved for themselves and the Medical School at the Final Examination for the degree of M.B. at the University of London. By reference to the table below it will be seen that Guy's has come out well at the top in Honours. Our candidates have secured twelve honours in the three subjects—four more than St. Thomas's, who are second on the list—and Mr. A. H. Leete is to be specially congratulated on obtaining the Gold Medal and Scholarship in Medicine, which has thus fallen to a Guy's man after eight years; we may also extend our congratulations to Mr. F. J. Steward, who was the only candidate placed in First Class Honours in all three subjects.

MEDICINE.

First Class Honours.

Guy's.	Thomas's	Bart.'s.	Mary's.	Univ.	Owen's College.	London.	Middx.	L.S.M.W.
3	2	0	2	1	1	0	1	0

Second Class.

3	2	2	1	1	0	1	1	1

Third Class.

1	1	2	1	0	0	0	0	3

Yorkshire College. 1

OBSTETRIC MEDICINE.

First Class.

Guy's.	Thomas's.	Bart.'s.	Mary's.	Univ.	Yorkshire College.	London.	Middx.	L.S.M.W.
2	1	1	0	0	0	0	0	0

Second Class.

0	2	1	1	0	0	0	0	0

Third Class.

0	0	0	0	0	1	1	0	1

FORENSIC MEDICINE.

First Class.

2	0	0	2	1	0	1	1	0

Second Class.

0	0	1	0	1	0	0	0	0

King's. 1

Third Class.

1	0	0	1	0	0	0	0	1

In the Pass List Guy's also occupies a gratifying position. Out of the seventy-one successful candidates twelve were Guy's men, and of the twenty-one placed in the First Division six were from Guy's, a larger number than any other Medical School can show.

For the splendid specimen of Koodhu horns recently added to the adornment of the Smoking Room, the Students' Club is indebted to Col. F. Babington Peile. We can assure Col. Peile that his gift is as much appreciated as it is admired, and we gladly take this opportunity of conveying to him the thanks of the members of the Club for his kindness.

With our Christmas Number, which will appear on Saturday, the 29th instant, we shall present to our subscribers a reproduction of the famous picture which represents Thomas Guy conferring with Dr. Mead, the Physician, and Mr. Stear, the Architect, upon the plans for building Guy's Hospital. As this Supplement has only to be seen to create a large demand for *extra* copies, orders for these, accompanied by a remittance of one shilling (postage threepence extra), should be sent early to the Librarian.

The index and title-page of the present volume of the Gazette will be issued as soon as the numbers for 1894 are complete. Subscribers desiring to have their numbers bound should leave these with the Librarian as early in the new year as possible.

Inasmuch as this is the last appearance of the Gazette before the 25th inst., we must seize the occasion to wish our Readers, the Treasurer and Staff of the Hospital, the Nursing Staff, and, lastly, the Patients for the time being amongst us,

A HAPPY CHRISTMAS.

It is neither our province nor desire to insist here upon the general responsibilities which

attach themselves to this season, but there are several matters peculiar to Christmas at Guy's which demand emphasis in these columns. Firstly, the Patients' Christmas Dinner Fund, to which every Student should feel it a pleasurable duty to subscribe.

Secondly, the "Christmas Box" to the Students' Club servants. We would remind members that now is the time for a material recognition of attentions so often received without acknowledgment; but never allowed to be absent without complaint. Lastly, the postman's "Christmas Box." Any one acquainted with the vast amount of correspondence which passes through the front Lodge and the College, knows perfectly well that the postmen have exceptionally heavy work to do — for the students personally. It is a distinct reproach, therefore, that sixpence should have been the amount which represented last year the united subscriptions of the students to the postmen's fund. We would suggest a collection box being placed at the front Lodge to attract that attention which is perhaps what has been lacking in former years.

We are pleased to hear that the Christmas Nigger Troupe will give an entertainment to the Nursing Staff of the Hospital during Christmas week, by the kind permission of the Matron. Any who have had to do with Christmas Festivities will understand to what an extent the Sisters and Nurses of the Hospital work to make the week an enjoyable one for the patients under their charge. It is, therefore, all the more gratifying to know that they themselves have been allowed to participate in the enjoyment of the Nigger Entertainment.

"In a House of Pain," by Frederick Vynon, a review of which will appear in our Christmas Number, will be read by most people acquainted with life within the walls of a large London hospital with a considerable amount of interest. The story deals chiefly with the troubles of a popular House-Surgeon and the object of his affections (a lady pupil), and contains much quiet humour, and at the same time some deeper moralizing passages which may attract many. Some of the characters will seem familiar to most Guy's men, who will not be slow in detecting the Hospital in which the author—himself, we believe, a medical man—has gathered the materials for his interesting novel.

We publish to-day a second letter on the Photographic Studio, in which the writer corroborates the statements made by "One who is Keen" in our last issue. That there is really a reasonable ground for grievance seems to be true, and we hear that some of the Photographic Committee have already taken some action in the matter. The Presidents of the Physical Society will doubtless sift the affair to the bottom, and, after calm deliberation, bring things to a harmonious issue.

Guy's has of late been figuring strongly in County Football, H. T. Bell, H. W. Dudgeon, R. Rowlands, and K. B. Alexander having appeared in the Surrey ranks; C. R. Nicholson for Sussex, and F. C. Wetherell for Kent.

The Rugby XV. seem to be a strong lot forward, and, if report is true, there will be a keen struggle for the last three or four places. This is as it should be; at the same time, it is more than unfortunate that we are deprived of the services of some of our best backs through injury. As the season goes, the team have on the whole performed creditably, and with our very *best* representatives always in the field, we

might reasonably be expected to escape defeat through the rest of the winter.

The Christian Union will meet on Thursday next, at 4.30 p.m., to hear an Address by A. W. Brown, Esq. (of Christ Church, Oxford), on "Sanctifying of Work."

The Treatment of some Diseases by means of Thyroid Extract.

A Paper read before the Pupils' Physical Society by Mr. L. A. Parry, M.B.

(*Concluded.*)

Now, of the special forms of skin diseases on which this drug may be supposed to exert some influence, perhaps psoriasis is the most important. The following are short particulars of Dr. Bramwell's first case. H. McK., æt. 18, was admitted into the Edinburgh Royal Infirmary with psoriasis, which covered almost the whole of the body. The disease was of nine months' duration, and had been treated with the usual remedies. Thyroid was then administered for four weeks, and marked improvement took place; the eruption disappeared from all parts. Treatment was continued for one month more, but an arrest of the improvement took place. Thyroid was therefore discontinued, and arsenic substituted. The change was very unsatisfactory; the eruption began to reappear. After ten days thyroid was again tried, and in three days' time the disease was noticed to be lessening, and in a fortnight she was practically cured. She was discharged a month later, the skin all over being perfectly normal and healthy. No local applications whatever were used.

He has treated a large number of cases since then on similar lines, and has come to the conclusion that it is a potent remedy for the disease. Many other distinguished observers have come to the same conclusion, but it is only fair to state that other equally celebrated dermatologists hold quite opposite views, and consider the results obtained by Dr. Bramwell as merely coincidences, the thyroid, in their opinion, having no effect at all on psoriasis or other skin diseases.

Lupus is another of the skin lesions which has been benefited by this method of treatment. At first sight it might seem that the employment of thyroid in a tuberculous affection of the skin was merely empirical; but it is well known that patients affected with myxœdema not at all unusually die from tubercle, and therefore, it may be concluded, are specially liable to this affection. If this is so, it is very likely that the absence of thyroid from the juices and tissues of the body predisposes to tubercle. It is not unfair, then, to conclude the converse proposition, namely, that thyroid extract may perhaps prevent the development of tubercle, or exert a beneficial influence on tuberculous lesions already present, and especially cutaneous tuberculous lesions, considering the special trophic influence on the skin exerted by thyroid. Dr. Bramwell treated two cases of this disease by the internal administration of thyroid, no local application whatever being employed, the patient not even being allowed to remove the scabs. A marked improvement ensued; the progress of the disease was checked and partial cure took place. Active lupus is not a disease in which there is any tendency to cure, and therefore Dr. Bramwell thinks he is justified in attributing the improvement to the treatment employed. He, however, advocates as the most effective means of dealing with this disease a combination of local treatment and internal administration of thyroid.

Mr. Lane has had very good results with thyroid in lupus, several cases treated by him showing a noticeable alteration for the better. The probable mode of action of the drug is by improving the nutritive condition of the skin tissues, and thus enabling the cells to overcome the encroaching tubercle bacilli, which are the active agents in the production of the disease, or to resist the injurious influence which the toxines produced by the bacilli exert upon them. An alternative theory to this is that the thyroid extract has a directly antagonistic action on the micro-organisms of tubercle. However, these are only theories, and the practical question is, Can we hope that this may become a means of curing lupus?

There are a few other skin affections to which I must briefly refer before leaving this part of my subject. Dr. Leslie Philips, of Birmingham, treated a case of xeroderma in a patient of 44 with thyroid. It was a typical case, with fine, dry, silvery desquamation; 10 minims of Brady and Martin's extract was given daily for 12 days, and the skin became softer and more scaly. After a month's treatment he showed considerable improvement, the skin was much less dry and the scaliness had disappeared. The patient also asserted that he had perceptible perspiration while in bed, a contrast to the absence of perspiration which is so marked a feature in xeroderma.

Dr. Bramwell also treated a case of ichthyosis with large doses. When admitted she had a noticeable odour about her, like that of a corn on a horse's legs—very great improvement took place in all the symptoms. Dr. John Gordon, of Aberdeen, narrates the following case: A woman, aged 49, with a squamous eruption, very like psoriasis, but undoubtedly syphilitic, was treated for five weeks with iodide of potash and arsenic internally, and chrysophanic acid ointment externally. Very slight improvement occurred. All treatment was then stopped for one week, at the end of which time, 20 minims of Brady and Martin's extract were given daily. In a fortnight there was a great change, the patient herself said she felt very much better in her general health. A week later the disease was cured, but the thyroid was

continued another fortnight; the improvement in her general health was not sustained, she complained of malaise and pains in her limbs. Dr. Gordon, commenting on this case, said that syphilis was most certainly present, that the skin lesion undoubtedly improved under the thyroid treatment, and that at first the general health of the patient was also better.

There are many other cutaneous affections for which this remedy has been employed, such as scaly eczema and pityriasis rubra. So far it has not been tried in a sufficiently large number of cases in any variety of skin disease for any definite conclusions to be drawn. Personally, I think the proper course to pursue is to try the ordinary treatment; for example, arsenic and some tarry ointment for psoriasis, and give it a fair trial. If it fail, I believe, considering the cases I have quoted are only a few samples of a good number in which the drug seems to have had some observable influence, I say I believe that thyroid is well worth a trial. I would not use it as a routine practice in cases of psoriasis, for example, but only in chronic cases that refused to react to the ordinary modes of treatment.

The next disease of which I shall speak, but only very briefly, is that rare and peculiar malady known as acromegaly. It is now just ten years ago since Pierre Marie, of the Salpêtrière, described, from two cases he had observed in Charcot's clinic, this disease for the first time, though previous to this several cases had been recorded under such names as gigantism, exophthalmic cachexia, general osseous hypertrophy, etc., but to Dr. Marie is undoubtedly due the merit of recognising it as a distinct malady, and of accurately describing it. The symptoms are characteristic, and a well-marked case is easy of recognition. Taken in the order in which they first attract attention, the hands are enlarged and massive, often widened and thickened; there are projections on their palmar surfaces like pads; the fingers are also enlarged in a similar manner, but they are not noticeably lengthened; the rest of the arm may be a little enlarged, but not to anything like the extent of the hands; the feet and lower limbs are similarly affected, but the increase in size is less in proportion than in the upper extremities. The face is curiously altered in appearance—the upper jaw is thickened and the face lengthened from above downwards; the lips are thick, the tongue enlarged, the skin of the face is pigmented, and the whole appearance is quite pathognomonic. There is slight lumbar curve with the convexity forward and a marked cervico-dorsal curvature; the ends of the ribs and sternum project, and thus a double-hump is formed; the neck is thick, the voice is altered, and menstruation ceases; there are headache and pains in various parts; appetite and thirst are excessive; changes of vision are present, and the whole of the symptoms are characteristic.

The pathological anatomy is peculiar—the pituitary body is constantly enlarged, sometimes very much so; the thyroid gland is altered, and the skeleton presents various changes.

Pathologists have now for some time regarded the pituitary and thyroid bodies as very similar; microscopically the anterior part of the pituitary body is practically identical in structure with that of the thyroid. A case recorded by Dr. Woolcombe of psammoma of the pituitary body was accompanied by a subnormal temperature throughout, and also loss of knee-jerks at an early stage—both symptoms constant in myxœdema—another link in the chain of similarity between the pituitary and thyroid bodies. Presumably their functions are similar: if in this disease there is a deficiency in pituitary secretion, it may be possible to replace this deficiency by means of thyroid juice—it is, I am afraid, hopeless to get pituitary glands in sufficient number. The disease is so rare, and the suggestion for treatment by thyroid so recent, that hardly any cases have been tried. However, up to this, no treatment has even been suggested, except, perhaps, for the relief of symptoms. Therefore it would be only reasonable to employ this method, considering it is founded on rational measures and that it has been so successful in the analagous disease, myxœdema. So far, I have only been able to collect the record of one case which has been treated in this way. It was that of a patient who had had the disease for a very long time, and was given up as quite hopeless before thyroid was tried; she certainly improved on it, but poisonous symptoms were so easily produced that the treatment had to be given up, and I am afraid the patient is rapidly dying.

In conclusion, I must just briefly refer to the effects of thyroid feeding on some varieties of insanity. The line of argument which led to its employment in such cases was as follows: the administration of thyroid produces a slightly feverish condition; mental improvment, sometimes even recovery, occurs in insane patients after various febrile attacks, such as erysipelas and scarlet fever. If by this artificial method we produce a slight febrile state, it may be possible to imitate Nature's method of cure.

Thirty cases of different types of insanity, including mania, melancholia and chronic insanity, were treated with this substance by Drs. Macphail and Bruce at the Derby County Asylum—ten males and twenty females; of the ten males, one recovered, five were relieved, four were not improved; of the twenty females, thirteen recovered, two were relieved, and five were not improved. As the result of their investigations, they consider this new method of treatment is a valuable addition to the means of attacking insanity. They also state that the drug is contra-indicated in acute mania and melancholia where there is rapid wasting, and in cases of phthisis and hear t disease.

Time will not allow me to make any reference to many other interesting facts in connection with this subject—I have been obliged to treat even many of those to which I have referred very cursorily—however, I hope any points I have not made clear may be raised in the subsequent discussion.

Results of Experiments on Seventeen Cases of Psoriasis.

CONTRIBUTED BY J. W. H. EYRE, M.B.

Class I.

Treatment:— Liq. Arsenicalis, Vin. Ferri Cit. } q.s. Inf. Quass. ad ʒi., t.d.s.

Sex.	Age.	Result.	Cured in — weeks.	Relapsed after — weeks.	Remarks.
M	18	Cured	7	4	...
M	24	Cured	12	...	No relapse after 6 months
F	8	No Impt. after	21 w'ks	...	Transferred to Class IV.
F	19	Cured	10	...	Transferred from Class II.

Class II.

Treatment:— Tabloidi Thyroid (B. W. & Co.)

Sex.	Age.	Result.	Cured in — weeks.	Relapsed after — weeks.	Remarks.
F	33	Cured	8	...	...
F	56	Cured	14	6	Atrophy of Thyroid
M	22	Cured	14	...	...
F	19	No Impt. in	20 w'ks	...	Transferred to Class I. Palmar Psoriasis

Class III.

Treatment:— Local applications only. Ung. Acid. Chrysophanici or Ext. Picis. Liq.

Sex.	Age.	Result.	Cured in — weeks.	Relapsed after — weeks.	Remarks
M	37	C	21	...	...
F	20	C	24	8	...
M	11	C	36	..	...

Class IV.

Treatment:— Tab. Thyroid and Ung. Acid. Chrysophanici.

Sex.	Age.	Result.	Cured in — weeks.	Relapsed after — weeks.	Remarks.
M	28	C	7	...	0 relapses at end of 6 months
F	30	C	10	...	
F	15	C	12	...	
M	22	C	15	...	
M	8	C	7	...	Transferred from Class I.

Class V.

Treatment:— (As control subjects) Sacch. Ust. ɱiv. Aq. ad ʒi., t.d.s.

Sex.	Age.	Result.	Cured in — weeks.	Relapsed after — weeks	Remarks.
M	36	C	6	...	Epileptic. Has attacks of Psoriasis every 6—9 months, lasting about 1 month. Does not think medicine accelerated his recovery.
F	24	No Impt. in	31 wk's	...	...
F	13	C	12	3	...

N.B.—1. Treatment in every case continued fourteen days after recovery.

2. With one exception (noted above) the thyroid glands of these patients were, *as far as I could make out*, normal. Psoriasis not being a fatal disease, I was unable to examine the thyroids post-mortem.

3. The patient in Class II., afterwards transferred to Class I., was a case of Palmar Psoriasis, upon which anti-syphilitic treatment had been unsuccessfully tried.

4. The first three cases in Class IV. were very severe, the Psoriasis being distributed all over the body.

Examination Papers.

Royal College of Surgeons, Eng., Nov., 1894.

DIPLOMA OF FELLOW—FIRST EXAMINATION.

Anatomy.—1. Write a full account of the Curves of the Spinal Column including their uses. 2. Describe the course and relations of the Inferior Vena Cava. Enumerate its branches and give an account of its development. 3. Describe the Muscles attached to the Cricoid and Arytænoid Cartilages, together with their actions. Give the steps by which you would expose them, the Larynx having been removed from the body. 4. Give the superficial origin, course, distribution, and communications of the Glosso-Pharyngeal Nerve.

Physiology.—1. Discuss the chemistry of Blood-clotting and contrast it with allied phenomena observed in other animal substances. 2. Describe the principal experiments by which the position and physiological relations of the Vaso-motor centre have been determined. What effects are produced by:—(*a*) Faradization of the peripheral end of the divided Vagus below the origin of the Superior Laryngeal Nerve? (*b*) Similar stimulation of the central end of the divided Depressor Nerve? (*c*) Stimulation of the central end of the divided Sciatic Nerve? 3. Describe the minute structure of the Urinary Bladder, and explain the Physiology of Micturition. What are the Physical and Chemical changes that Urine undergoes when freely exposed to the air? 4. Describe a Graafian Follicle and the manner in which it is developed. What changes occur in the Ovum previous to fertilization?

Viva Voce for the Primary Fellowship.

ANATOMY.

The candidate was given an ulna.

"What bone is this?"

"Mark in the attachments of the anconeus, and supinator brevis."

"What is the use of the groove below the lesser sigmoid notch?" "To allow the bicipital tuberosity of the radius to rotate in."

The os calcis was next given to the candidate and its position in the body, its use, and the part it takes in the formation of the arch of the foot inquired about.

"On which side of the foot would you come down upon when jumping from a height?"

(Dissection of the pterygo-maxillary region).

Candidate was required to name the various arteries, muscles and nerves pointed out in this and in subsequent dissections shown him.

"What is this?" (Int. pterygoid muscle).

"What is the direction of its fibres, its action, and what muscles act with it?"

"Enumerate the arteries supplying the tonsil?"

"What are the superficial and deep relations of mylo-hyoid muscle, submaxillary gland and Wharton's duct?"

(Dissection of the anterior triangle).

"Where would you look for the vertebral artery?"

"How would you expose it; and trace it to the skull?'

"What is the chief variation of the basilar artery? The persistence of the median septum since it is formed by the coalescence of the vertebrals?"

"Yes."

"What other artery has often the same variation, and how do you account for it?"

"What does the aberrant artery represent, and what is its relation to the œsophagus?"

(Dissection of the foot, plantar surface.)

(Dissection of the back of the leg.)

"Is the posterior tibial its normal size in this subject?" "No."

"What artery takes its place, then?"

"Give me the anastomoses of the posterior tibial artery?"

(Dissection of the popliteal space.)

"What is the insertion of the adductor magnus? and the relation of the adductor tubercle to the epiphysis of the lower end of the femur?"

The ossification of the femur and insertion of semi-membranosus were next inquired about.

(Dissection of the muscle of the back.)

"What is the nerve-supply of the latissimus dorsi and serratus magnus?"

"What is the action of the serratus?" (*Bell.*)

PHYSIOLOGY.

"What is that under the microscope?"

"I do not know."

"Have you ever seen anything like it before?" "No."

"Then you are not likely to recognise it."

"Tell me what you see here. A section of pancreas?" "Yes."

"How do you recognise it, and what distinguishes it from a mucous gland?"

"How is it stained?"

"Look at this, now (a section of cardiac end of stomach). 'What is the difference between the cells of the cardiac and pyloric end of stomach? Can you see the two kinds of cells in that specimen? How would you demonstrate the parietal cells?"

"Have you ever prepared specimens for microscopical examination yourself?" "Yes."

"Tell me how you would prepare a section of stomach if you were given a piece of fresh tissue?"

"What is Muller's fluid?"

"What are the advantages of alcohol as a hardening fluid?"

"What is under this microscope?" (A section of ovary.)

"How do you recognise it?"

"Would you say that the ovum you see there was well developed or not?"

"What is the principal organic substance in urine?"

"Give me its formula, chemical composition, and the tests by which you would recognise it."

"How would you prepare it from fresh urine?"

"Where do you find most uric acid in the body?"

"How can you prepare urea from uric acid?"

"By oxydizing with nitric acid and decomposing the acid into alloxan, etc., and by further oxidation the alloxan can be converted into parabanic acid. By hydration this last can be converted into oxaluric acid, and this can be converted into oxalic acid and urea?"

"Yes."

A bottle, labelled "Wittes' Peptone," was given to candidate, who was asked to do the Buiret test.

"How would you separate the various albumoses present?"

"What is Buiret, and how do you obtain it?"

"What is the effect of injecting peptone into the blood?"

"Have you ever prepared glycogen yourself?"

"Yes."

"Tell me exactly the steps you took."

"What is its formula, chemical composition, and what tests would you apply to demonstrate its presence in a liquid?"

(*Bell.*) A. W. O.

Pass List.

University of London, October, 1894.

M.B. EXAMINATION.

EXAMINATION FOR HONOURS.

MEDICINE.

FIRST CLASS.

Leete, A. H., obtained the Scholarship and Gold Medal.
Manning, G. E. Steward, F. J.

SECOND CLASS.

Davies, Hugh Hopkins, F. G.
Taylor, E. C.

THIRD CLASS.

Hovenden, A. C.

OBSTETRIC MEDICINE.

FIRST CLASS.

Steward, F. J. Taylor, E. C.

FORENSIC MEDICINE.

FIRST CLASS.

Manning, G. E. Steward, F. J.

THIRD CLASS.

Hopkins, F. G.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

L. P., RAMSGATE.—The specimen you sent was a multilocular ovarian cyst, containing a good deal of muscular tissue; there were no evidences of malignancy.

H. A. L., SWANSEA.—The bottle was received here broken, and the contents all but gone. The examination of what was left showed nothing definite, a few pus cells being all that could be made out.

G. F. H., BALHAM.—No tubercle could be found in either specimen, No. 1, No. 2, or No. 3.

B., DORKING.—Urine acid, sp. gr. 1·013, in a state of fermentation, a moderate quantity of albumin present; no casts recognised in specimen. Urea 7 per cent.; no sugar. PATHOLOGIST.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Photographic Studio.

DEAR SIR,—I am sure the letter of "One who is Keen," in your last issue, expresses the general feeling about the Photographic Studio. May I suggest that, instead of election by ballot, members be chosen according to their *photographic* capabilities, as this will ensure better work being turned out. To the casual observer, the Studio is a dusty neglected place, but I feel convinced it has possibilities far beyond its looks, and in the hands of really *active* members we might hope for some good results.—Yours, &c.,

ANOTHER WHO IS KEEN.

Obituary.

EDWARD MIALL DOBINSON, Surgeon R.N.

We have recently heard, with regret, of the death of Surgeon E. M. Dobinson, H.M.S. *Imogene*, which occurred suddenly on the 17th ultimo, from pulmonary embolism. The deceased officer, formerly of Lee, Kent, entered Guy's in 1883, and served all the ordinary appointments. He also obtained distinction as Dresser to Mr. Brailey in the Eye Wards, to Mr. Symonds in the Throat Department, and as Clinical Assistant to Drs. Pavy and Pye-Smith. He qualified M.R.C.S. Eng., L.R.C.P., and L.S.A. in 1891, and in the same year entered the Naval Medical Service.

Early this present year, while stationed at Constantinople, Surgeon Dobinson contracted typhoid fever, which was followed by femoral thrombosis. After a walk of five miles, on November 7th last, he was frequently attacked with dyspnœa, which became more severe on the 15th. He was then removed to the Naval Hospital at Malta in a very collapsed condition, from which he rallied slightly. On the afternoon of the 17th, however, another attack of dyspnœa set in, which was shortly followed by death.

During his stay at Guy's, Surgeon Dobinson proved himself to be a thorough student, and his unassuming nature gained him many friends who will sincerely regret his early demise.

Short Sayings of Great Men.

"The man of refinement and sensibility will know instinctively how to proceed, and needs no instruction. They who lack these qualifications can never learn, and it would be quite useless to undertake to teach them. I sincerely wish such men as these latter would find some more suitable employment than the practice of a humane art."

"In youth the real plastic energy is not in tutors, or lectures, or in books 'got up,' but in Wordsworth and Shelley, in the books that are all read because all like; in what all talk of because all are interested; in the argumentative walk or disputatious lounge; in the impact of young thought on young thought, of fresh thought on fresh thought, of hot thought on hot thought; in mirth and refutation, in ridicule and laughter; for these are the free play of the natural mind, and these cannot be got without a college."

"One dram of mirth will sooner mend thy crasis
Than twenty bitter draughts, with scurvy faces.
Let chemist or the Galenist prevail;
Yet sure a course of mirth is worth 'em all.
No drug, nor hellebore, no rhubarb safe;
O still, the only physic is to laugh."

Reviews.

Diseases of the Upper Respiratory Tract: the Nose, Pharynx and Larynx. By P. Watson Williams, M.D., Lond. (John Wright & Co.). Price 8s. 6d.

Written by a general physician with a special knowledge of the subject treated, this book is strikingly free from the grave faults which are almost always to be found in books written by specialists. The descriptions of the various diseases are short, clear, and to the point, and are illustrated by excellent diagrams. As the author is a physician first, and a specialist afterwards, the medical affections of the throat are naturally treated at greater length than are the surgical ones. For the specialist, the book is apparently somewhat deficient in detail, but it may be warmly recommended to the general student as a concise, clear and sufficient account of the affections of the upper respiratory tract. The important subject of differential diagnosis is carefully handled, and is rendered simpler by the free use of tables. Perhaps the most evident fault to be found with the book is the author's tendency to assume that the reader has had a somewhat extensive experience, and hence requires hints, where, perhaps, careful descriptions would be more suitable.

Areo-therapeutics, or the Treatment of Lung Diseases by Climate, being the Lumleian Lectures for 1893, delivered before the Royal College of Physicians, to which is added an address on the High Altitudes of Colorado. By Charles Theodore Williams, M.A., M.D. Oxon., F.R.C.P., Senior Physician to the Hospital for Consumption and Diseases of the Chest, Brompton, late President of the Royal Meteorological Society. (Macmillan & Co., 1894.) Price 6s., net.

The author has given a pretty full account of the meteorological conditions met with at the various resorts frequented by patients suffering from diseases of the chest. Dr. Williams' wide experience of chest disease, together with his thorough knowledge of meteorology, has rendered any work from his pen upon the subject valuable, but we confess to a feeling of disappointment after a perusal of the book before us. A large number of statistics and reports of numerous cases are given, and there is a fairly full account of the treatment by compressed air. The practical information given is, however, small, so that on the whole the book does not help one much in the actual treatment of cases of chest disease by climate. We cannot but feel that the book is an account of individual experience, rather than a scientific consideration of general principles, and this appears to us unfortunate, in that on such a subject the experience of any one man must be very limited.

Diphtheria: its Natural History and Prevention, being the Milroy Lectures delivered before the Royal College of Physicians of London in 1891. By R. Thorne, C.B., M.B. Lond., F.R.S. (Macmillan & Co.) Price 8s. 6d.

The publication of these lectures at the present time is especially apt, on account of the universal interest which has been excited by the new antitoxin treatment of diphtheria. Their value is further increased by the fact that they present an aspect of the subject which is frequently overlooked, treating it rather from a public health point of view, *i.e.*, dealing with its relationship to the State rather than to the individual.

The natural history of the malady, gathered from observations upon its course and spread in England, especially in the rural districts, is dealt with at some engths, whilst a brief account of the scientific history, starting with Bretonneau's classical memoir, which was written in 1821, is given. This account, however, cannot be compared, either as regards detail or completeness, with Dr. Roth's review of the subject in the June number of the *Jahrbuch für Kinderheilkunde.*

The way in which the disease is spread is exhaustively discussed, and is copiously illustrated by the consideration of cases. Finally, the author points out how this spread may be prevented, and mentions the precautions that should be adopted by the authorities during an epidemic.

Elements of Surgical Pathology. By Agustus J. Pepper, M.S., M.B. Lond., F.R.C.S. Eng.; Fellow of University College, London; Surgeon to St. Mary's Hospital, and Teacher of Practical and Operative Surgery at the Medical School. Fourth edition, rewritten and enlarged. (Cassell & Co.). Price 7s. 6d.

This edition does not differ in any essential point from the last one. However, it is fuller in some respects and is well up to date. Amongst the various diseases, upon which lately a good deal of work has been done, the author treats both Actinomycosis and Mycetoma. Although these subjects are but briefly described, yet the recent investigations which have been made in connection with them are mentioned. We think it a little unfortunate that in dealing with Actinomycosis, the term "coccus" should have been used to described the spores before they have commenced to vegetate, as the use of this expression in this sense is decidedly misleading. A short account of Bacteria is given; this, in our opinion, considering the enormous importance of this subject in surgery, might have been extended with advantage.

Dissections Illustrated: a Graphic Handbook for Students of Human Anatomy. By C. Gordon Brodie, F.R.C.S., with plates drawn and lithographed by Percy Highly. In four parts. Parts II. and III. (Whittaker and Co.) Price 10s. each part.

The two parts before us of this useful handbook are quite up to the somewhat high standard of the first one. The lithograph plates, which are excellent copies of careful dissections, are drawn to a somewhat larger scale, and in consequence are somewhat clearer. This is further increased by the fact that they are a little deeper in shade than are those in the first part. The book is certainly to be recommended to students who wish to remind themselves of their former dissections; and these volumes, whilst not so useful as our own wax models, will yet be of great value to those who are less fortunate than we are at Guy's.

Physiology for Beginners. By M. Foster, M.A., M.D., Professor of Physiology in the University of Cambridge, and Lewis E. Shore, M.A., M.D., Fellow of St. John's College, Cambridge, and Senior Demonstrator of Physiology in the University of Cambridge. (Macmillan and Co.) Price 2s. 6d.

This little volume, which contains only two hundred and thirty-three pages, deals with all the facts of Physiology and Anatomy, the knowledge of which is necessary to anyone who wishes to take an intelligent interest in the subjects. The vast field which is covered in so limited a space has rendered great conciseness unavoidable, and this, although advantageous in some respects, unfortunately renders the book less fascinating than it might have been, and at times makes the authors' meaning somewhat obscure. However, on the whole, the subject is well treated, and this book can be safely recommended as one of the best of the many popular elementary books which have been written, and will serve as an excellent introduction to the study of Physiology. The value of the volume is further enhanced by the many excellent diagrams which it contains.

Primer of Hygiene. By Ernest S. Reynolds, M.D. Lond., M.R.C.P., Senior Physician to the Ancoats Hospital, Manchester, University Extension Lecturer on Hygiene. Price 1s. 6d.

If it is an advantage to students in the University Extension Classes to have the least possible amount of information that can give them a right to say that they have studied Hygiene, presented to them in a form that can be readily assimilated, then this book will serve the purpose of providing it for them. It is clearly written and well arranged, but otherwise has no special advantages above the many other small books which have been written upon the subject. One strong feature in favour of the book is, that it insists, with some detail, upon the disadvantages of tight lacing and narrow-toed boots.

Guy's Hospital Dental Department.

Practice during November, 1894.

Gold Fillings	338	
Amalgam ,, ...	506	
Osteo ,, ...		
Perm. G.P. ,, ...		
Regulations	2	
Artificial Crowns	56	
Dentures	9	
Dead Teeth	168	
Scalings	51	
Attendance for Extraction under Anæsthetics ...	1127	
,, ,, without ,, ...	719	
Total	2976	

Sport.

Rugby Football.

GUY'S v. OLD MERCHANT TAYLORS.

This match was played off at Old Deer Park, Richmond, on a very good ground. From the first it was evident that the game would be very evenly contested. The forward packs, both sides, were heavy; and although we had slightly the better of the play in the scrimmage, the O.M.T.'s were superior to us in the loose. Trouncer and Jackson at half, worked admirably, the former looking very much like scoring after a long run down the field, but he was neatly tackled by the opposing full-back, and, alas! there was no three-quarter near to whom he might have passed the ball, and for whom there would have been a clear "run in."

In the first half of the game, Guy's were slightly the better team, but after half-time we were more or less penned in our own territory, and scrimmage after scrimmage took place on our goal line; the pressure was successfully relieved by Trouncer, Jackson, and Bell. During the last ten minutes the O.M.T.'s redoubled their efforts to score, but the Guy's men answered to their shouts, and drove their opponents over the half-way line; but when the whistle blew "time" the score still remained nil on either side.

It was unfortunate that Bell's knee gave way so early in the game, but, although partially disabled, he played a good game. Morgan was anxiously watched, but with the play chiefly amongst the forwards, he had few chances, but of these he made good use.

GUY'S 2nd XV. v. SIDCUP.

Played at Sidcup on Saturday, December 8th, and resulted in a win for the local team by two tries to one. For the first few minutes the ball was kept in Sidcup's 25, but by some good kicking the play was transferred to neutral territory. A series of scrums here followed, in which neither side gained ground. The Sidcup backs getting possession of the ball after a good piece of passing, scored their first try; the kick at goal failed. Guy's kicked-off from 25, and immediately began to press. Good runs by Jones and T. Morgan put Sidcup on the defence. Biggs securing from a pass by Hicks, scored; the shot at goal failed. At half-time the scores were equal. Sidcup kicked off, and T. Morgan returned well, but some faulty lining up on the part of Guy's forwards enabled Sidcup to obtain the ball, and after another bit of good passing they again scored. The kick at goal did not increase the score. Guy's pressed for the remainder of the time, and several times looked like scoring, but were not able to do so, leaving Sidcup victors by two tries to one, after a fast and exciting game.

Guy's forwards worked hard in the scrums, and were better than their opponents, but they should try to get possession of the ball more. The most prominent, perhaps, were Wood, Carter and Saward. Of the backs, Clarke at full did all that was required of him. T. Morgan put in some very useful runs and kicked well. Biggs, Jones and Hicks also played well; but the combination of the Sidcup outsides was much superior to that of our men. Team:—

Guy's.—W. T. Clarke (full back); A. C. Ransford J. J. E. Biggs, T. Morgan, H. P. W. Barrow (three-quarter backs); H. T. Hicks, M. P. Jones (half-backs); A. J. Cleveland, A. H. Saward, A. H. Carter, M. D. Woods, J. N. Gardiner, A. Kinsey-Morgan, H. V. Bagshawe, G. Shorland (forwards).

Association Football.

GUY'S v. OLD BRIGHTONIANS.

Played at Honor Oak Park on December 1st, 1894. We had a very moderate team, being without Fitz-Hugh and Carter, the latter disappointing us at the last moment. The play was of a fast and exciting order, each team, in turn, attacking, but the defence on both sides was very safe. After twenty-five minutes' play, the Old Boys obtained their first and only goal, by which point they led at half-time.

In the second portion of the game, Guy's attacked strongly, and after twenty minutes' play Thornley equalized with a long shot. The play continued to be very exciting, and within a minute and a half of time, Guy's obtained "hands" in front of goal, from which Humphrey notched the winning point.

Our play was a decided improvement on that of the previous Saturday; Walker, Crosby, and Palmer were the pick. We are glad to see that the latter has improved wonderfully, but is still at fault in trying too many long shots at goal; with this fault cured, he is likely to be one of our most dangerous forwards. Team:—

Guy's.—M. S. Barker (goal); F. Walker, K. Goadby (backs); M. H. Thornely, E. J. Crew, A. E. Crosby (half-backs); P. S. Mandy, W. G. Palmer, F. Kirk, R, B. Stamford, L. Humphry (forwards).

Appointment.

Joyce, J. H., B.A., M.B., B.C., has been appointed House-Surgeon to the Kent and Canterbury Hospital, *vice* A. C. Elliman, resigned.

Births.

ALEXANDER.—On December 1st, at Trinity Square, S.E., the wife of John Alexander, M.R.C.S. Eng., of a daughter.

CLOWES.—On December 10th, at Reading, the wife of Norton B. Clowes, M.R.C.S. and L.R.C.P., of a daughter.

DIXON.—On the 9th inst., at Tyldesley, Manchester, the wife of George F. Dixon, M.R.C.S., L.R.C.P., of a daughter.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers, who may be desirous of having their numbers of the GAZETTE *bound, should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

DECEMBER 29, 1894.

1894.

ONCE again we have reached the close of another year "in the history of the GUY'S HOSPITAL GAZETTE," and with it we feel it incumbent upon us to give a short account of our present status. We have no hesitation in saying that not only has the journal maintained its best traditions, but more than this, for during the past year its great activity has been strikingly shown by a permanent enlargement to thirty-two pages. For this state of things we have to thank in a large measure our staff of contributors for the assistance they have so freely given us, and with them we must include Messrs. Ash & Co., and especially their works manager—Mr. Seabridge—for the indefatigable interest and courteous manner which they have always displayed in the publication of this paper. In addition to its enlargement, we have been enabled to publish, through the kindness of the Staff of the Hospital, a clinical lecture—occasionally two—with almost every number, to report in full all the papers read before the Physical Society, and latterly the transactions of the new Dental Society, as a special supplement. There has been a notable increase in the number of illustrations, specially in those of interesting cases which we have from time to time received both from present and past students of the Hospital. With regard to the Hospital News, we have also made some improvement, in that by an arrangement with the Registrars the list of cases has been established as a permanent item in our columns. We cannot help feeling, however, that more is wanting in the accounts of special cases contributed by those working in the wards; we would again impress upon them that the matter which is most appreciated by our readers should not only include uncommon features of the case, but also the clinical teaching—the "points" discussed by the physician or surgeon which these features suggest to *his* mind at the bedside.

In dealing with Hospital News, we must not forget to mention the Out-patient notes which have occasionally appeared, and among which have been contributions from "Skins," "Surgical," and "Obstetrical Out-patients." We have but lately received one from "Throats," which it is our intention to insert in the next issue, and we should be glad to receive notes of interesting cases from the Post-mortem room and other departments, such as "Eyes," "Ears," from time to time.

In April, 1893, the Gazette undertook a scheme for the description of pathological specimens in its columns. This column, "From the Gazette's Special Pathologist," by a steady increase in length, has fully justified the claims made for it. Indeed, its success paved the way for the more ambitious undertaking which has already made a name for itself as the Clinical Research Association.

Lastly, an arrangement has been made between ourselves and the Library Committees, by which the Gazette will be kept supplied with reviews of all the latest and best medical works.

All these improvements, however, while satisfactory enough in themselves, so far from satisfying the editorial mind, have only served as indications of the vast fields of increased value and usefulness which lie before this journal. It is a pity to think of stores of material going to waste, and we hereby appeal to everyone connected with this great Institution, whether by present or past ties, whether at home or abroad, to co-operate with us in making these columns a perfect mirror of the life, work, thought and teaching of Guy's men and women.

Christmas at Guy's.

(By our Special Reporters.)

The Decorations.

The signs of Christmas approaching are very marked in the neighbourhood of Guy's Hospital for some time beforehand. Sisters and Nurses bustle in and out of the front gates with all the activity of pleasurable business. As they go out the most stupid man sees "shopping" written on their faces, and on their return the nature of the spoils are obvious. Gradually the wards become a blaze of colour; the cart of the piano manufacturer becomes a familiar sight, the Top Lodge assumes the appearance of a combined Parcels and Post Office, with Cloak-Room thrown in. Parsons, as Postmaster-General and Traffic Superintendent, Sorter and Porter, displays the generalship of a Napoleon; his poor little "window" is a bit trying, but it gallantly overcomes the tendency to burst, and who could break an old acquaintance at Christmas-time? And so, gradually, the bonds of discipline become not loosened but softened, and—with Christmas Day—Staff and Students, Sisters and Nurses, Patients old, young, and little children, join as members of a common family, finding their kinship in the spirit of the hour.

IN THE SURGICAL WARDS.

The Surgical wards, from their very age and architecture, lend themselves to decoration with very little difficulty. It was accordingly to be expected that each would vie with the other in the elaboration and ingenuity displayed in the arrangement of its Christmas adornment.

The generally picturesque appearance of Patience and Samaritan is heightened by the quiet and homely effect produced by the chains of variously-coloured paper rings, with holly and evergreens here and there over beds and windows, while the Hospital crest facing the entrance is to be much admired.

From Patience to Dorcas is like stepping from the simple home of the cottager to the boudoir of the æsthete. We hardly know which to admire the most, the contrast is so marked. Dorcas has always prided itself, and justly, we think, on the delicacy of its decorations, and by the employment of exquisitely-tinted yellow paper, interspersed with chrysanthemums, moss and evergreens, the decorators have produced a design which makes the fireplace especially one of the best adorned in any of the wards. Across the passage, through a gaily-lighted doorway, and the "scene is changed."

Charity has wreathed its windows from end to end of the ward with holly and evergreens in the same style; its low roof is hung with lanterns of every size, and it is evident that no pains have been spared to make the ward cheerful and bright. The cots, too, have received attention, being prettily draped with curtains of white wool, over which ivy is trailed. Along the upper corridor, sharp to the left, and we are in

Luke, where an original idea has been conceived in the arrangement of the lanterns. These are hung solely between the beds,

which are gaily decorated with small flags and wreaths, giving the ward a somewhat martial aspect. Fancy lamps are employed to advantage round each bed and at the fireplaces, which here also show signs of artistic care, while the gas brackets are tastefully decorated with yellow art muslin, ivy and baskets of artificial flowers.

The doorway of NAAMAN is very prettily decorated with small ivy, and its big lanterns gave the ward a charming appearance as we saw it on Christmas night. A lingering look, and we are obliged to hasten on to

LAZARUS. The doorway, draped in its traditional manner with the old colours, leads us into an avenue of evergreen festoons, among which are seen tiny many-coloured fairy lamps, and the celebrated "Japanese baby" lantern dangles from the roof, seeming to breathe defiance as "the lost child(?)." We retrace our steps, and get a charming view into

JOB through its ivy-decked entrance, above which shone the title of the ward in letters of fairy lamps. Nowhere in the Hospital has holly, and that of the choicest, been employed to such good effect. The graceful festoons hanging from bed to bed and across the front of the ward harmonise in a pleasing manner with the warm red coverlets, and well repay the trouble and patience which must have been expended in their wreathing. A forest of lanterns shed a brilliant light on the animated scene when the niggers performed. Sprays of ivy, trailed round the windows and above the mantelpieces, complete a charming picture, which it is hard to beat.

From Job we proceed to LYDIA, which also is beautified with festoons of ivy hung round the entire ward and prettily draped round fireplaces and gas brackets with yellow and green material. The lanterns here are hung at a good height and the ward deserves the admiration it has received.

In MARTHA the terra cotta colouring of the walls, embellished with thick wreaths of evergreens round the windows and head of each bed, and from side to side, is pleasant to the eye, and the lanterns are quite the prettiest in shape and colouring we have yet seen. The fireplaces are effectively draped in the Guy's colours, the middle one being further adorned with the Hospital crest, which is in itself a work of art. As we glance upwards on leaving the ward we are greeted with "A Happy Christmas" in frosted letters on a red background. Down the old staircase, we arrive in the colonnade and turn first into

CORNELIUS. Wreaths of holly leaves ornament the walls and hang gracefully from the ceiling. Flags and lanterns add to the brightness of the decorations, and in the back ward a Hodgin has been tastefully ornamented with red cloth and entwined with ivy, of which the occupant of the bed seems to be justly proud. On with the niggers we enter

ACCIDENT, where flags of every description predominate also. The globes of the gas brackets are hidden by big Japanese butterflies, and, in spite of a busy "take-in," time and skill have been employed to good purpose in hiding the usually subdued appearance of the ward. A warm effect is produced with red cloth fringed with yew and draped round the fireplace.

IN THE MEDICAL WARDS.

IN spite of the extreme difficulty which must be attached to decorating on an extensive scale the huge wards in Hunt's House, it was gratifying to find how much has been done to add to their beauty in the short time allotted to the decorators.

In the EYE Wards we were wished "A Happy New Year," and were immediately struck with the extremely tasteful arrangement round the fireplaces. Both mantelpieces are charmingly decorated with small delicate-leaved ferns and mistletoe peeping from a background of moss; one especially attracted us in which the mistletoe is drooped over the moss in a perfect cascade.

From RUTH and BARNABAS, up the broad stone staircase to the left, and MARY is entered. Drapery in blue and gold over the arches, masses of evergreens on the gas brackets, with an occasional loop and festoon across the divisions, have been extensively employed, and numbers of lanterns and tinted gas shades are in evidence.

In PHILIP a somewhat Eastern effect is produced with Indian drapery, and a very handsome Guy's crest is suspended over the fireplace next the door.

In STEPHEN, in addition to the usual amount of evergreen, holly, and ivy wreathing, and the many coloured lanterns suspended at various heights, there is a large representation of the ever seasonable legend, "A Merry Christmas," which, if report speaks true, the patients have enjoyed to the letter. Down again—how much more might be said if only time and space would permit—across the road and into "sacred precincts."

Clinical wards (John and Miriam) have been most thoroughly ornamented, and the pillars and fireplaces have received careful attention. Evergreens, coloured papers and drapery predominate, and even the *Kitchen* can boast its little display of holly, and "Alexander" has been washed and looks as only "Sandy" can look at his best, even though Mr. —— [personal allusions distinctly prohibited.—Ed.]. Genial clinicals, what a jolly time, *and* the bread and milk!

Our task is finished, though we are aware that we have, perhaps, not done full justice to the Christmas decorations, and, truth to say, it were well nigh impossible. The festivities we must leave to other hands; '94 at Guy's will be a Christmas-time to remember for many years to come. To the many kindnesses of the Nurses and Sisters the patients are indebted for a truly happy time, and in conclusion we must take the opportunity to thank the Nursing Staff and the Students for the pains they have taken in the ceaseless labour involved in the decoration of the wards for Christmas week.

The Guy's Ethiopians.

After being duly photographed, as per usual, our far-famed troupe—not inaptly termed the "Guy's Disguysed Minstrels"—made its *debût* punctually at 1.30 p.m. in the Eye Wards. The fun soon became fast and furious, and the pitch of excellence so quickly reached here was indeed but a foretaste of the whole afternoon's enjoyment, for it was kept up without a semblance of flagging from start to finish, although in a few wards it was perhaps even surpassed.

Thomas opened the ball with "Pepita," earning well-deserved applause, and Scott-Turner raised roars of laughter with his "Jimmy on the Chute." The troupe then went upstairs to Bright, and, forming up, marched round to the strains of "Black Bess." Stephen was the next port of call, Hicks being heard to perfection in "Honey, my Honey," with a chorus by the troupe that went beautifully. Spon, as usual, was well to the fore with "Macnamara's Band," singing with rare dash and vigour. Then we adjourned to Philip, to a treat by Sergeant, who sang "Baby" very sweetly, earning well-merited applause, while Robinson fairly shook the ward with his rendering of "Razors in de Air." Mary came next and a large audience awaited the troupe. Messrs. Michael, Spon, and Robinson gave an amusing knockabout sketch, illustrating what the Gaoler did, "*with cuts.*" The "Alabama Coon" was given by Michael, followed by a banjo trio, highly appreciated. Then Trouncer sang "Far away ober dare" in great form; and Spon made a big hit with "Rumti, Tumti." After being refreshed with the cup that cheers, etc., and the last adieus being said, amid general regrets, we adjourned to Clinical, where, in accordance with an ancient custom, revived this year, the Staff and Students were to meet at tea. Here, amidst picturesque surroundings, we found Dr. Wilks and Mr. Durham the same as ever; Drs. Hale-White, Perry, and Pitt, Messrs. Golding-Bird, Symonds and Lane also being present. Scott-Turner trotted out "The Tin Gee-Gee" to the evident delight of the audience; and "Joshuah" (Pendred) was well received. "Massa Johnson" sang "Sing along, Sambo" with great *éclat*; and "Duck-foot Sue" was given as Robinson only can sing it. Hicks and Thomas sang "The Man in the Moon" as a duet, the refrain of which is likely to haunt Clinical for some time to come. Then once more the troupe partook of the tea and other good things provided for them. After a short interval, the journey was made to Patience and Samaritan, and here once more Bones carried all before him, while Cann's "Nellie Gray" gave evident satisfaction. In Dorcas the great feature was Messrs. Thomas and Hicks' duet, which once more obviously made a great impression.

The second half of the lengthy programme was commenced in Charity with the "Alabama Coon," the chorus of which was most effective. Spon then gave us "Macnamara's Band" again in killing style. The niggers were here once more regaled with the ever-welcome tea. In Naaman Hicks and Scott-Turner were again much appreciated, and Mr. Bones fairly surpassed himself. On to Luke, where Fagge sang "The Old Folks at Home" with much feeling, and Spon convulsed everybody with his weird story about "The Horse in the middle of the Tube," and Robinson's "I'm off to Charlestown," with its harmonious chorus as a finale, went with a splendid swing. After Lazarus had been given "Mandalay" and "Pepita," things became extremely lively in Job, where everyone now knows what the Gaoler did. "Lazily, Drowsily," with hushed chorus, was quite one of the best items in the programme. Tambo's "Rumti, Tumti" was again received with great enthusiasm, followed by "Far away ober dere"

as an extra turn concluding the performance—before leaving for Lydia, where things reached a climax with "Three Little Piggeys" and "Duckfoot Sue," both of which were pronounced on all sides as "thundering" good. In Martha, "The Tin Gee-Gee" and "Good-bye, Susan Jane" were once more enjoyed by the ever-increasing audience, and more tea was again provided before the long round was brought to a close by visits to Cornelius and then to Accident, where, after a large dose of the very best, a most successful five hours' entertainment was terminated by Hicks' "Good Night."

The troupe this year, we can say without the slightest fear of contradiction, was certainly one of the best, if not THE best, which good old Guy's has ever seen. It was agreed on all sides that the great feature this year was undoubtedly the excellent rendering of all the choruses, this being plain evidence of the careful and thorough manner in which the training of the troupe had been carried out. And for this our special thanks are due to the untiring energy of Messrs. Slater, Robinson and Hardenberg. The first, as Massa Johnson, was all that could be desired, and the last performed his share of the duties, and that by no means a light one, throughout the afternoon with great zest and verve.

The costumes were excellent, far greater variety being shown this year in their choice than we have seen before, and thoroughly repaid all the trouble which had been spent in their elaboration.

Selections from that Programme.

Dere Massas SLATER & HARDENBERG,

It am rather rough to grind out more of this unmewsical stuff, when we's done it befive—we mean before—but we're gwine to chance our luck, and if we're collared for being too forward in going backwards to reach the goal, you must put it down to our being off-side—off colour, we mean—through the network of Vestry and Guardian scrummages we have been playing in. However, we will set the ball rolling and not drop it till we touch down, so wave the flag, even though the referee blows the whistle before we try to score our far-fetched try. We'll heel out and give our halves a chance to feed the three-quarters, as they are hungry for poetry and we can't pass that back who nearly stopped us before without a bit of dodging. Now for the struggle:—

His Very Latest!

"Pepita," says **THOMAS,** to sing won't take long,
With the "Old Folks" **FAGGE** takes a hand;
Next, "Rumti Tumti" shall be **SPON'S** song—
"Fusillade" with the great **BANJO BAND.**

"Sing along, Sambo," dear Rugger **SLATER,**
HARDENBERG will play with real zest,
But **CANN'S** "Nellie Gray" can't stay any later
Though "Mandalay" **POOLE** sings his best.

ROBINSON dotes on his "Duckfoot Sue,"
And throws his "Razors in de air,"
Shouts out "I'm off to Charlestown," too,
With **TROUNCER** "Away ober dare."

"Good-bye, Susan Jane," kiss **MICHAEL** for me,
HICKS' "Honey" can never go slow,
PENDRED'S "Joshuah" will make you drink gallons of tea,
SCOTT-TURNER'S "Tin Gee-Gee" won't go.

This awful mix-up we must end very soon,
But we hope we have caused no one grief;
Let **MICHAEL** sing us his "Al-a-bama Coon,"
And that will afford you relief.

The **SERGEANT,** not "Lazily," takes off his boot,
For "Baby" has woke in a fright;
Through **SCOTT-TURNER** slinging the lot "down the chute,"
So **HICKS,** to make peace, sings "Good night."

On this stuff, please, don't pass many strictures,
We know we're not clever, but mad;
Give the patients the meaning of our "living pictures,"
And they never no more will be sad.

NIGGERS' ANTHEM, HERE, Please.—Hot, with lemming.

P.S.—We didn't like the above ridiculously-worded stuff, so we hasked the Hoffis Buoy to slowly evolve out of his gigantic little brain the following, on his own:—

A dose of fun is better than a pill,
So open wide your mouths and take your fill.
The Editor of this is quite knocked out
And hardly knows which way to look about.
The Parish Councils Bill has druv him nearly mad,
But no "Tin Tacks" on earth could make him sad;
His sobriety's a query, so said the man so tall,
"Dis ear and dat air," that quite, new joke (?) did all.

As the programme artist slowly wended his way through the colonnade, he didn't know whether to laugh or cry, and he dropped the following, which was picked up by the black man with the little dawg:—

One dram of Massa near made me choke with larfter,
I couldn't stand;
But Trouncer's song I'll think of ever after,
It was so grand.

The melodies were beautiful to hear,
Were more than good;
Each one sang well, and all deserved a cheer
And Xmas Food,"—etc.

The Festivities.

Dinner on Christmas day in the wards of Guy's was, as usual, thoroughly enjoyed by all who partook of it, and not the least by those favoured individuals who had the pleasure of carving for the patients. After the patients had been supplied with fruit, toys, etc., and with smoking materials in the male wards, the Sisters and Nurses, together with the above-mentioned favoured individuals, had dinner together, as is customary on these occasions. We cannot help commenting on the excellence of the roast beef and plum pudding which the Students' Dinner Fund supplies, and we ourselves felt, after tasting them for the first time, that we could not have wished for anything better.

After dinner, the spare time before the arrival of the Niggers was occupied by lighting lanterns, adding last touches to the decorations, etc., and where the wait for the arrival of the troupe was a long one, it was passed pleasantly enough in the study of the well got up and ludicrous Programme, for which we are so much indebted to Messrs. Ash & Co., who, with their usual kindness, again presented a copy to each of the patients.

In addition to the Nigger performance on Christmas Day, no pains have been spared to provide amusement for the patients, by means of concerts. Thus, on Boxing Day a good programme was carried out under the direction of Mr. R. H. Fagge, in Luke, during the afternoon, while in the evening, the patients in Naaman, together with a large gathering from other wards, listened with evident delight, to the well-known songs contributed by Messrs. Michael, Spon, Hicks, Thomas, Scott-Turner, Poole, and others. Mr. Hardenberg is to be congratulated on the success which attended his efforts.

In Mary, on Thursday afternoon, a concert, arranged by Mr. A. G. Butler, was given to an appreciative audience by "La Madrileña, Amateur Mandoline and Guitar Band."

On Friday, the following were among those who contributed to a first-rate entertainment :— Mr. James Dunn, with musical sketches, Miss Ethel Davies and Mr. Fred Upton, with recitations, and Mdlle. Patrill, with conjuring.

A party of ladies and gentlemen, including Mr. Ellis Reynolds, Mr. and Mrs. E. Vivian Reynolds, and the Misses Keen visited Charity during the afternoon and performed a programme of songs, recitations and music, which gave great pleasure to the patients, and the few others who were fortunate to be present.

In the evening, a concert in Ruth and Barnabas, which was arranged by Mr. Zumbado, was given by artistes—including Señorita Lopez, the Misses Gerrard, Herr von Ruthmüller, M. and Mdlle. Flatau, and Messrs. Lulham, Callingham, and Brindle—drawn chiefly, we believe, from the Royal Academy of Music, before a large company, who seemed thoroughly to have enjoyed themselves.

In the other wards the musical geniuses of the Hospital have been utilising every opportunity to play on the very excellent pianos which the London manufacturers have so kindly supplied.

The following, we understand, to be the arrangements for the next day or two :—

To-day (Saturday), concert at 4.30 p.m., and Christmas-tree at 6 p.m. in Martha; Punch and Judy in Accident, and magic lantern show at 7 p.m. in Luke. Both Christmas-tree and lantern show are intended for the children, the former having been provided through the generosity of Mr. Golding-Bird.

On Monday (New Year's Eve), there will be a grand concert in Philip, under the direction of Dr. Bryant, from 4 till 6 p.m.; and in Job the Lucasites have arranged one to commence at 6.30.

The Opinions of No. X. (— Ward).

Yes! Christmas in 'Orspital's crummy, for them as is gettin' on gay,
An' can take on their grub an' amoosements, as is both on 'em reg'lar O.K.,
An' Christmas is all werry nice for them as 'as wittles an' tin,
But it 's 'ard on a cove as 'as neither, an' ain't worth an (adjectived) pin.
As yer've asked me to spin yer a story, I'll pitch it as well as I can,
Tho' my subject ain't over-excitin', me bein' but an ornery man:
Last week, then, I come out o' chokey—it ain't o' no int'rest what for,
Bein' simply a slight disagreement 'tween me an' the heyes of the lor—
An' I meets an old pal as was lucky, an' 'ad an 'arf-dollar to lend;
An' 'e ses to me, "Culley, 'ere keep it—and take the adwice of a friend,
Don't blue it on nose-paint an' baccy, but make an inwestment like me;
Leave p'leecemen alone in their beauty, an' don't let yer langwidge go free;
You buy a few dozen o' matches—just keep a bit back for a doss—
An' I'll put yer right on the knocker: yer shan't make no (qualified) loss."

So I takes it—but would yer believe me—'twas only the werry nex' day
As I 'eard 'e was nailed by the peelers, for practisin' my little lay.
(Them slops is so aggerawatin', they puts on the airs of a don,
No wonder there 's some of 'em spoilt, when they will keep a movin' yer on.)
Well, I still 'ad some capital left, so, upset-like, I goes for a wet,
Just to drink to my pal doin' 'is stretch, for 'is Chrismas ain't merry, you bet!
An' yer know how one thing allus does, it leads on to another so slick,
That I swallered the lot and got mazy, an' was chucked in the street bloomin' quick,
An' I came a kermozzlin' slump on my 'ed in the slippery mud,
An' the last thing I know'd that there evenin', was the sound of that wallopin' thud;
Then I woke with a thirst like a cabman's, my foot in some nice little boards,
An' that 's 'ow I came to be landed, a case in Guy's 'Orspital Wards.
It seems as a light-'earted cart-'orse 'ad tried a step-dance on my shin;
They calls it a Pott's dislocation—it 's compound and busted the skin—
So I'm in luck's way for a while, for I'm dry-docked an' takin' a rest,
An' I ain't been so cared for an' tended, since mother, wot's gone wi' the blessed,
Nussed me, when a lad in the country, I nigh broke my neck stealin' eggs;
For they've done me a treat, them there stoodents, an' I'll leave with a good pair o' legs.
I've learnt a few things, too, by watchin', as ain't in them elegant books
As is werry improvin' an' pretty, though their pictures ain't quite got the looks
Of the *P'leece Nooze*, which fair takes the biscuit,—but as they was lent me by Nurse
It makes me feel better to 'old 'em, an' I 'ave seen some tracts as was worse—
I ain't goin' to peach on my pals, as 'as made a noo man outer me;
But them lanterns from China 's a caution, an' ward-decoratin' 's a spree,
An' screens are promiskus an' 'andy, an' eight o'clock makes a ward dark,
An' if I was a stoodent myself, I'd be on for a bit of a lark.
So "Onny swaw key mally ponse," as is Frenchy for "innercent fun,"
There's no 'arm in the lot of 'em, bless 'em, an' Christmas-week collars the bun,
As a time for young Coopid's manoovers, an' a couple o' sparklin' blue eyes,
With a cap set above 'em, looks fetchin', *an' so ses the dressers at Guy's!*

L.

Popular Medicine.

By Senex.

Neque semper arcum tendit Apollo.

It was customary in former days for the young physician to see patients gratuitously, at his own home, once or twice a week during certain hours. This practice not only enabled him to become known in the neighbourhood, but afforded him, moreover, opportunities for prescribing. Whilst following this method, and making notes of cases, I often jotted down the expressions verbally employed by the patients, for they were often very pithy as well as being amusing. I have now, during a leisure hour, been turning over my note-books and transcribing some of the medical phrases used by the proletariat, thinking that they might find a place in the column of the Gazette which is devoted to light literature—a column evidently intended to relieve the reader who, perchance, has been fatigued by the very valuable but somewhat severe and trying pages devoted to clinical medicine and pathology.

In looking over these notes, I am struck with the great favour humoral pathology finds amongst the poor as compared with that of solidism; nevertheless, aerial pathology, as it may be called, supplants them both. The ailments arising from corruptions of the blood are manifold, but they are few compared with the complaints which fly about the system; perhaps the idea conveyed by this expression is not far removed from that which the learned call by the more euphemistic name of "metastasis." It may be here remarked that the word "system" has a depth of meaning unknown to the profession, and therefore when the phrase "something on the system" is employed, the diagnosis is highly significant. There seems to be some innate delicacy of feeling which makes the poor choose high-sounding words and vague generalities in order to avoid odious particulars. We may, therefore, infer that they attach some hidden meaning to the word "system," in the same way as they do to the expression "internal complaint." In this spirit, women's special functions can only be spoken of as "them things," for we find at the climacteric period "them things" are constantly dodging and flying about the system, whilst in the young girl "nature" has not appeared.

I would not for a moment suggest that this popular medical philosophy is confined to the fair sex, for men also, I observed, had a strong belief in those erratic complaints. It was a man who bitterly complained that "the gout was flying all over him and would not settle anywhere." But, as before said, although not couched in technical language, the idea conveyed does not differ much from that which one daily hears from the mouths of the *élite*. Amongst women, the time of the menopause is one of never failing interest, but the allusion to it is still wrapped up in the most general terms; for a woman referring to this condition, although not blind, was impelled by modesty to inform me that she had "seen nothing for four years last Tuesday." Another woman,

very fat and yellow, said she had been very confidently assured that if the doctor who attended her at the change of life "had cleared those things away, he might have prevented them forming into gall-stones." This belief in the doctor's powers is very wonderful; exemplified in the words of a patient who said, "I went to the doctor and he said, how many children have you had, and I said eight. He then said, you have had enough, and stopped my courses." Many instances I have noted of the great faith placed in medical skill. For example, a woman told me that I had once seen her son with disease of the heart. "I brought him to you," she said, "and you gave him something to prevent it being known when he passed his examination." A patient with cataract said, "if you put my stomach in order I know it will clear my eye." Another woman told me that I once had her husband under my care for pain in the head and blindness. I cured him of the pain, she said, but I was frightened to cure his eyes lest I should disturb his brain. I might add that the terms referring to metastasis are very often merely figurative, as when, for instance, a woman presents her ricketty child who is unable to stand, and states her belief that he is cutting his little teeth in his little loins.

Many curious expressions are due to ignorance or want of education, and so the character of Mrs. Malaprop is not unrepresented amongst the poorer classes. Thus, varicose veins may very pardonably be styled "very coarse veins," but one old lady always persisted in calling them "vericacious" veins. Another had "little ulsters on her stomach, for which she took 'sidulitz' powders, as she had bad indigestion and that sort of thing." But, as I before remarked, women are not peculiar in misusing words, for it was Mr. Ramsbotham who said he had very "fluent" bowels, and another man who declared that his bowels were "ecstatic"; he meant, he said, "erratic, for, in fact, there was great imbecility of action." An epileptic told me that he fell down and lost his "conscientiousness," and he was afterwards informed that he had "stentorious" breathing.

Amongst my notes I find the case of a woman who said, "My boy has had the intermediate fever, and this has now turned to a rackety cough, so I gave him some syrup of quills and a little scotchineal." To quote another, "I have four of them down with the measles; they wrestle about a good deal at night, but my children are given to grit their teeth and foment at the mouth." Another woman informed me that her children "mourned so at night, especially when they were cutting their high teeth," and she added, "My little girl is liable to information of the bowels, so that all she cares about is laying, as she can't sit." It was a man who said that "His wife was not well where they lived, for it was not a very embracing place." Again, one man told me he gave his wife some "consecrated beef," and another that he had "consecrated bowels." A boy had, according to the mother's account, "bronchitis of the lungs, with a great wheezling in his chest and a great congregation of phlegm, which corroded his liver." A very vociferous lady, when relating her troubles, and dwelling more especially on the loss of her husband, and with him her income, ended her speech by saying, "He is now dead and left me comparatively a widow."

It is not only wrong expressions but the explanations as to the nature and causes of the complaints which strike one as curious. A poor man told me that his doctor said "my headache is owing to too much blood flowing to my brain, and the membrane of the brain cannot absorb it." Another who had doubtless heard of the cranial sutures, said he believed "his headache was due to pressure on the brain when the skull was fixed, he ought to have begun his studies earlier," Another brought me her idiot child, and informed me that "there was no doubt about his intelligence but he could not apply it." A middle aged shrew said of her asthmatic husband "I believe asthmatic people are of a sulky disposition, the sulkiness makes them asthmatic, they won't let their feelings out." A man said he was troubled with wind in the stomach, he took in more air than he could get rid of; and a woman with constipation, that she inherited it as her bowels were paralysed before she was born. A nursing woman said her husband worrits her and this does her milk no good.

It is worthy of remark how amongst the uneducated there is a kind of instinct to lay hold of the right word and a tendency to follow the rules of grammar, so that a word is coined which would be correct were not the verb irregular.

Thus, there is often a force in the expressions not to be got out of the usual vocabulary. The word "worreted" is very commonly used and sounds much stronger than "worried." When a man has "squenched" his thirst he seems to have satisfied it much more thoroughly than if he had simply "quenched" it. The letters *d* and *t* as finals seem to add much force. The lower orders say, The lad gradually got "worst." He only took it "onst" a day. He had a lump in his little "groind." The lengthening a word also adds to its force—"My water is as clear as 'chrystial,' the doctor gave a very high character to it." I was recommended to you by the "curiate" in our village. As regards the pronounciation of many technical words, I apprehend the popular method is right when the word has become anglicised; for example, as the spirit of the English language is to throw the accent back on the first syllable, I consider abdomen as usually pronounced is more correct than the professional one of placing the accent on the second syllable, and so with several other classic words which have got into ordinary use, as pemphigus, anemone, etc.

Here, again, are several other strange expressions I find before me, as a mother saying of her boy "his head is too strong for his body; his body is a complete failure." Again, "my whole system is charged with acid matter," or "he once had a tape-worm, but it is changed into a thread-worm, and he says the worm bites him." Retching where nothing is evacuated is called "dry retching," and sometimes "screaming retching," which seems synonymous with the "screeching sickness."

I never quite understood what a patient meant by stating she had "the creeping piles up her back," neither have I arrived at the true signification of the "rising of the lights."

The diseases of which people die, are sometimes curious, as one patient told me his father died of decline and indigestion; another of natural decay brought on by gout, and a third that his father died of puerperal fever. Irishmen are expected to say strange things. It is not surprising, therefore, to find Pat, after having injured himself by falling from a height, saying, it was not the fall that hurt him, but it was stopping so quickly. Another Irishman, being asked if he could move his paralysed arm, answered "he believed four men could not move it." No one but a son of Erin would have said that his diarrhœa was so bad he could keep nothing on his stomach. Amongst other oddities, I find a patient who had been bitten by his dog saying, "I know it won't hurt me, for he lives on the best of food like myself," and another, a female patient, that she could no longer suckle her child, as she had "broken the main spring of her nipple"; whether the metaphor was suggested by a fountain or by a watch, I never understood.

Exaggerated and grand expressions are very pleasing to patients, especially if they can say that the doctor had never seen such a case before. Amongst the higher class it is a great satisfaction for women to say that they cannot take a particular kind of medicine, and also that although they look well they have a remarkably weak pulse. There is great fondness for technical expressions, for instance, when one woman told me she had paralysis of the womb; a second that she suffered from secretion of the lower bowels; or, as a third patient informed me, that Bader took out her eye and removed three chalky ulcers and an abscess. A man once came to me with cerebral symptoms and said he saw double, upon which his wife exclaimed, "It's no use going to the doctor and making the best of things, saying you see double; you know you see three or four things." Language is often hyperbolic amongst the poor, as "the perspiration drops off him like peas, and when he gets over it he is like a little corpse." A woman, speaking of her late husband, said "he was so strong it took him a week to die." A man said the parish doctor told him "he had caught cold in the glands of his stomach," and that "the blacks in India could not have worse bile than he had." A woman with lupus erythematosus said the doctor told her that "her outer skin was as thin as Prince Leopold's."

The people who are imposed upon by quacks in all classes of life are those who pretend to understand and want matters explained—for instance, a man brought me his wife who had a pain in her back, which I called neuralgic. The husband very bluntly said he wanted to know the reason of things and was not content with a fine word. Their previous doctor had thoroughly explained to him how one of the joints of the spine had had its oil dried up, and so the bones rubbed together. This he could understand, as it was reasonable. Another man said he was suffering from his liver, but he always wanted to know the reason of things. On telling him it was his kidney at fault, at the same time showing him the albumen in a test-tube, he exclaimed, "Yes, I knew it was my liver, this albumen in the water is from want of action of the liver, as I have an itching in the seat, and I know enough of anatomy to know that the liver and kidney touch one another." But then, a clergyman, a presumably liberally educated man, said "I know why indigestion causes palpitation, the stomach is intertwined with the muscles of the heart." The following is a curious piece of pathology: "The nurse was told to apply a leech to my nose for the headache, but the foolish woman put it to the gristle and thus lowered me without getting it out of my head." A few more odd expressions: The doctor says, "My boy has no marrow in his bones." Again, "I only eat meat three times a week, because, my wife being in an asylum, I lead a bachelor life, and it is necessary to keep down my vitality;" "I'm sure I have the gravel, I've seen it floating on the water;" "I don't know what the medicine was the doctor gave me, but it smelt so bad I was obliged to go into the garden to take it;" "I've lived twenty years on the basement floor and I think it has got into my system:" "He tried me for the water and then he tried me for the worms, but he couldn't find out what was the matter." I said to an epileptic: "Did you bite your tongue?" "No," he replied, "the fits just cleared my tongue."

It is a very common belief with women, to account for their abdominal pains, "That the after-burden grew to the side." The poor are not very charitable when alluding to parish doctors or hospitals, "He did not get on, so I called in a 'pay doctor,'" and "I had him under the skin places." In describing our feelings there is no doubt considerable difficulty, seeing we have no words to correspond to internal sensations. Here are examples: "I feel limp, like a wrung-out sponge;" "It's a nasty feeling to go about all day and not know how you feel:" "I feel as though I had lost something;" "My head feels like beating up eggs into batter;" "The medicine does not make me sleep, but produces in me a philanthropic state of mind;" "I feel so down I can't even read an indecent book with pleasure;" on telling a man "I don't think it's your liver," he replied "It's my own liver, and you'll allow me to know best."

I was constantly told what my speciality was; it included nearly every disease to which the human body is liable. Besides these, I have been told I am the physician for general weakness and debility. Also that I was very clever for acidity. Again that my speciality was the mucous membranes, and that was why my patient came, for she had suffered from the mucous membranes all over the body. This is much like one patient having pleurisy all over him and another sciatica in every part of the system.

Some of the strangest things I have heard are from hypochondriacs, but as these have been so mixed up with sexual questions I have not repeated them here; many of them being indecent and not fit for ears polite.

DOCTOR—"*And what's the matter with you?*"

BLUEJACKET—"*Well, sir, it ain't that I can't eat nor drink, but I gets a raking sort of pain fore and aft when I tries to work—mostly always does about Christmas-time.*

(Diagnosis: He wanted to have a merry Christmas.—Treatment accordingly.)

Passim.

Following close upon the triumph of the London M.B. come those of the B.S. and M.D. examinations, which furnished the unparalleled result that out of the thirteen candidates who presented themselves from Guy's in the former examination, and of the twelve in the latter, not a single one failed to pass. We understand, also, that at the Final M.B., B.C. Cantab, the Guy's candidates have also done well.

The Pupils' Physical Society will meet on Saturday next, at 8 p.m., when clinical cases will be shown.

The note in our last issue regarding the Postmen's Christmas-box contained a serious error; in fact, and worse still, inflicted an injustice upon our worthy Librarian. Mr. Mills, as those who know him best are well aware, is filled with the spirit of goodwill to all men, but his good works are done so stealthily, that in the present instance his very virtue has precipitated our offence. The true circumstances are, that last Christmas-time, Mr. Mills, out of pure good nature, worked the postmen's subscription list to such good purpose that a sum of thirty-four shillings was duly received, and duly handed over, and the "sixpence" which aroused our mistaken cynicism came from the college. We owe this apology and explanation to all parties, and sincerely trust that our unwitting lapse from truth may not be visited upon the innocent postmen.

The demand from Sisters and Nurses for extra copies of the Presentation Plate which accompanies this number, has been most gratifying, and we shall be glad to receive any further orders, from whatever source, as soon as possible. Arrangements have been made for the framing of the pictures at the moderate cost of three shillings each. Copies for framing may be left with the Librarian, or in the Matron's office, and will receive proper attention.

We are once more indebted to Mr. Gerald Sichel for the artistic production which faces "Passim" page. The incident which forms the subject of his clever sketch was one which, we believe, actually occurred to a Naval Surgeon but a short time ago. It will be unanimously agreed that Mr. Sichel's artistic temperament has lost nothing by his change of residence.

Our readers will be pleased to know that the Students' Dinner Fund for the patients reached the record this year of £60 8s., being over £5 more than last year. We are also glad to hear that a sum of something like £30 has been subscribed by the members of the Students' Club for the benefit of the Club servants.

The Entertainment given to the Nursing Staff by the Niggers, on Thursday evening last, was an unqualified success. The troupe was in fine form, and many of the songs and jokes went with an amount of dash that was almost remarkable. Among the numerous company there were present the Matron, Dr. Perry, Dr. and Mrs. Shaw, and the Chaplain. The Governors' Court Room, by kind permission

of the Treasurer, was fitted up with a platform which had been tastefully decorated with ferns and plants lent by Sisters Clinical, Eyes, and Stephen, and the few moments allowed between the acts, and at the end of the performance, for light refreshment and the interchange of social amenities seemed to be much appreciated by those who were fortunate enough to be present. We should like here to enquire why gatherings such as these cannot be more often organised on behalf of the Nursing Staff? Occasions like the one under notice afford an opportunity to the students of showing their real appreciation of the ungrudging labour of the Sisters and Nurses in the wards, and to the latter furnish a much-needed relaxation to the monotony and strain of their lives.

The following firms generously supplied the pianofortes used in the wards during Christmas week. We thank them most heartily:—

Messrs. Collard & Collard, Grosvenor Street, W.
" John Broadwood & Sons, Great Pulteney Street.
" John Brinsmead & Sons, Wigmore Street, W.
" S. & F. Erard, Great Marlborough Street, W.
" Blüthner & Co., Wigmore Street, Cavendish Square.
" Thos. D'Almaine & Co., Finsbury Pavement, E.C.
" Steinway & Sons, Lower Seymour Street, Portman Square.
" Charles Stiles & Co., Southampton Row, W.C.
" Chappell & Co., London.
Messrs. C. Venables & Co., Essex Road, Islington, N.
" Geo. Rogers & Sons, Berners Street, W.
" Cramer & Co., London.
" Pleyel, Wolff & Co., New Bond Street, W.

A correspondent writes to us from Wrington:—"I have taken the following from yesterday's *British Medical Journal*:—

"'It is proposed to found a lodge of Freemasons upon the lines of the Bar, the Apollo, and the Sir Isaac Newton Lodges, for those brethren who have received a part or the whole of their education at St. Bartholomew's Hospital.'

"Could not Guy's—or better, Guy's and St. Thomas's together—do likewise?" We commend this to the notice of some of the "brethren," who must be pretty numerous in and around Guy's.

The Students' Calendar for 1895 will be ready about the second week in January, and may be had on application at the Medical School Office. We would remind Students that reference to this reliable guide will save both themselves and others an infinite amount of trouble, especially as regards examination schedules.

In spite of the warning we gave in our columns some weeks back concerning the doings of pilferers, from the, alas, too frequent notices pinned on the boards, it appears that there are members still careless enough to have stylographic pens, hats, umbrellas, and even coats *mistaken*.

Thomas Guy,

FOUNDER OF GUY'S HOSPITAL, CONFERRING WITH DR. MEAD AND MR. STEAR (THE ARCHITECT), UPON THE PLANS FOR THE BUILDING.

The picture from which our presentation plate is taken was painted by Mr. C. W. Cope, R.A., and was exhibited in the Exhibition of the Royal Academy in the year 1871.

At the close of the exhibition the picture was offered by the painter to the Governors of the Hospital at a somewhat high figure. The Governors then, as now, having no money to buy pictures with, were obliged to decline the purchase, when the painter, with great liberality, presented it to the Governors at a nominal price, being the amount only of his annual subscription to the Artists' Benevolent Fund. The money was subscribed privately amongst the Governors themselves, and the picture has since hung in the dining-room of the Treasurer's official residence.

The picture is fairly self-explanatory, showing the excellent bookselling citizen in conference with Dr. Mead, the fashionable physician of the day, and Mr. Stear, the architect.

The house was situated on the site of the present Liverpool, London and Globe insurance office, at the angle of Cornhill and Lombard Street. Hence the view down Cheapside and the outline of St. Paul's in the distance.

The conference is, apparently, being rather abruptly disturbed by the waiting-maid's arrival with a frugal luncheon, which would be in keeping with Guy's well-known habit. Whether the damsel is the one to whom he lost his heart—and whom he would have married but for her supposed presumption in matters domestic—the legend sayeth not. The room and contents certainly have the appearance of belonging to a confirmed bachelor; that he remained so has, surely, been a matter of thankfulness to the sick and suffering for many a generation, no less than to the thousands who are proud to call themselves Guy's men.

Appointments.

JONES, CHARLES STURGES, M.R.C.S. Eng., L.S.A., has been re-appointed Medical Officer of Health for Chichester.

ROBERTS, C. GORDON, M.A. Camb., M.B., has been re-appointed Medical Officer of Health to the Halstead Local Board.

Specialism in Medicine.

I WISH to consider the question of Specialism, or specialization, in medicine, from the point of view of the general practitioner. Taking into consideration the proportion of medical students who are trained for general practice, and the proportion of the public who are treated by them, it is evident that the great object of our medical schools is, and ought to be, to turn out men well equipped to undertake a general practice.

The question, then, is whether specialism in our hospital schools is calculated to raise the standard of efficiency of the men turned out of them as qualified, nine-tenths of whom at least leave the schools to become general practitioners.

When about to choose my profession, I had the good fortune to meet the late Mr. Croft, and said to him, unaware that he was a surgeon, that I intended to devote myself to medicine, and asked whether I could avoid surgery altogether. He looked me over with a stern but not unkindly eye, and said: "The separation of Medicine and Surgery is an unholy divorce." I now know he was right. The absolute and indissoluble unity of the whole range of the healing art dawned on me and has more and more fully possessed my mind ever since. I shall never forget, a few years later, hearing one of the greatest physicians of modern times forget himself in the following manner while giving a clinical lecture. He spoke of a relative of his who suffered from laryngitis, and told how she had "Got into the hands of one of those" (after an ominous pause) "unhung—throat specialists. She died in an asylum." When men of the first rank express themselves thus forcibly, some of us may perhaps be excused for feeling strongly on the subject.

If the unity of medicine is holy, then is specialism in its popularly accepted sense unholy; if the separation of medicine and surgery is an unholy divorce, what is to be said of the judicial separation, granted in the highest courts of medical law, between medicine and gynæcology, neurology, rhinology, and so forth?

Bearing in mind that the hospital is the place where the student is to lay the foundation on which he must build for the remainder of his life, it behoves the teaching staff to see that such a foundation is laid as will serve to support a stable edifice. Can a proper foundation for a medical education, which ought to endure for life, be laid among specialisms?

Take an example from the ever-increasing list, dermatology—for the hospitals now permit the aggregation of "Skin out-patients." The student here learns to "Recognise as skin diseases," eczema, psoriasis, syphilitic eruptions, lupus, urticaria, shingles, etc. It must be evident to anyone who reflects at all that such a haphazard jumbling together of symptoms under the name of diseases must bring the student's mind, to make no mention of his teacher's, into a state of chaos from which it will probably never emerge. Or, in the name of common-sense, what are the diseases of the ear, that

a man should devote his life to their study? Is there any disease of the ear, if we exclude wax, that may not involve the rest of the patient, and so make it imperative that the otologist should be a thoroughly good all-round doctor; and if he is a competent all-round doctor, why does he call himself an otologist, and why should he send all cases that involve more than the ear to somebody else? To put it plainly: Is otology to be raised to the position of a separate science and art for the benefit of medicine and its students, for the benefit of the public, or for the benefit of the otologist? First, from the point of view of medicine and its would-be student: I have said before that medicine is either one great science, limited only by the range of human suffering, or it is no science at all. Secondly, from the point of view of the public, the otologist is either a conscientious, thoroughly educated and experienced "Doctor," or he is a dangerous character. The public is utterly incapable of deciding whether a case belongs really to the otologist or to any other specialist. Every specialist must, therefore, be thoroughly competent to examine each case and decide this question before commencing operations as a specialist. There only remains the point of view of the otologist, and for him I cannot speak.

The effect of special departments on the student is that, after wandering about from gynæcologist to dermatologist, and from laryngologist to ophthalmologist, he is driven to the conclusion that life is too short to make him all, or even some few, of these things, and at the same time a physician and a surgeon: so, after perhaps pursuing the specialists through a post-graduate course, he sinks (?) into the condition of a good hard-working general practitioner, and sends his patients and their guineas to the members of the learned professions above-mentioned.

The laryngoscope, the ophthalmoscope, and the auroscope are often just as essential to a proper diagnosis as the stethoscope and the thermometer; but it is beyond dispute that they are to a great extent neglected by the general practitioner, and regarded as peculiar properties—finger-posts denoting private preserves—of the Specialist. Are these instruments, and the study of the parts which they subserve, to be made really available—compulsory—for the ordinary student, or are we to go on "improving" till some one with a patent stethoscope is enabled to start a special "Heart Department"—of course, in the interests of medical science?

Do our teachers realise that the vast bulk of the people of this country must be treated, as a rule, during the treatable stages of their maladies, by general practitioners on their own responsibility, and that the great aim of medical education ought to be to produce men who can take case after case and say what the fundamental derangement is in each? If students were taught from the start that there is one great subject, and one only, and that by a patient, scientific investigation of each case, it comes in a few years within the reach of every honest man of ordinary capacity to say, with a very fair degree of accuracy, what the possibilities and probabilities are in each case, there would be some hope for them: But this endless specialization is unscientific and hindering, and makes men look on medicine in a disjointed and superficial manner.

The very essence of specialism is superficiality. The otologist invents microscopes to search for wax, and scorns the eye; the ophthalmologist must have ophthalmoscopes of "his own pattern," and scoffs at ear-wax; the dermatologist would have us believe that every patient who developes a "skin affection," in the course of no matter what disease, owes him two guineas; and the gynæcologist is lord of a realm that has not even a scientific frontier.

All organic diseases now appropriated by the laryngologist and gynæcologist are perfectly easy of recognition by any out-patient physician, and, if calling for operative treatment, ought to be treated on sound surgical principles by the best available surgeon. Has anyone ever visited gynæcological out-patients, or the private den of an eminent laryngologist, without feeling that if it were not for morbid neurosis there would be no demand for either? Operations on the eye are surgical operations, and not, as a rule, of a difficult nature certainly, and the abstraction of so-called eye cases robs the proper medical out-patient room of invaluable material, and to the average, or less than average, student, casts a most undesirable cloak of mystery round the eye.

While fully recognising that the separation of medicine and surgery is an unholy divorce, and that everyone ought to be educated with the idea that he must diagnose so-called surgical cases just as readily as medical ones, and sometimes perform a difficult operation like tracheotomy as best he may, yet we all recognise that, for the best performance of the more difficult and vital operations, a certain manual dexterity and a surgical nerve, two qualities that imply natural gift and long experience, are necessary. Therefore let there be, by all means, a number of men set apart for this work, after they have done their ten or fifteen years of general medical work and demonstrations of anatomy; such men are a necessity in all large hospitals and teaching centres. Beside these stand naturally an equal number of men of similar training and experience, who devote themselves to the medical side, in the restricted sense of the word. These men represent the pick of their generation; they are men of superior intellect, application, and experience, their natural place is in the hospital school, and in their consulting-rooms, whither we—the general practitioners—send them cases with the utmost confidence, to have our diagnosis confirmed, modified, or corrected. The relations of these two bodies of scientific men towards one another, and towards the body of the profession, are plain, honourable, and eminently satisfactory. The physician does not delay one moment, when necessary, in calling in the aid of the surgeon; neither does the surgeon ever operate without the advice of the physician, if he thinks the interest of the patient can possibly be served by a consultation. There is no case in existence that cannot be dealt with by such a staff. The broader a man's

view of medicine, so much surer is the prospect of a scientific diagnosis; and the more complete a man's grasp of the principles of surgery, so much the more thorough will his treatment be.

An otologist may wash out wax and drop in drops, but we all know that the most ordinary ear case may end in cerebral abscess and thrombosed jugular; the surgeon who is then required, might well have had the case all through. A case of phthisis need hardly leave a physician's hands to undergo laryngeal and intra-laryngeal medication at the hands of a specialist in the last stages of the disease.

Mental and infectious cases no doubt require segregation for purposes of treatment, but I see no reason why men should therefore spend all their time on these particular groups of diseases. Dentistry seems ambitious of being looked on as a specialism; no doubt the administration of anæsthetics is necessary for dental operation, but, apart from this, the complete treatment of the hair seems to me to have much more right to be looked on as a branch of medicine than dentistry. If a man calls himself a dentist, he ought clearly to resign the title of surgeon.

Specialism is good, or it is bad: its tendency is to advance medicine or to retard it. If it is good, let it be done thoroughly, let it develope on clear and stated lines; if it is bad, except within certain limits to be defined by the leaders in medicine and surgery, let its limits be by them defined. If the skin, the eye, the throat, the female generative organs, are worthy of having special departments and professors, surely the heart, the lungs, the kidneys, the brain, the liver, are being criminally neglected? That money is to be made by specialists, is beyond question, and that the public demands specialists, seems irrefutable; so specialists will be forthcoming, not only to look after every profitable part of the body, but to devote their genius to hydropathy, "Galvano-peutics," hypnotism, or massage, or any other healing craze the public may fancy at the moment. But each great school of medicine bears a great responsibility, and the time is at hand, if it has not already come, when a decision must be arrived at, whether medicine is a science capable of being taught as such, or whether it is capable of indefinite subdivision, for of specialism we have at present either a great deal too much or vastly too little.

I believe that the first school which emphatically proclaims the unity of medicine, which claims every useful instrument of diagnosis or treatment as the property of the profession generally and discards all others; the school which educates every student put under its care as one of a body of men who will tolerate no divorce between medicine and surgery, and will admit no superiority or distinction of the man who professes to be worthily engrossed in the study of skin or nose—I believe that school will mark a new epoch in the history of medicine.

The whole science and art of medicine are embraced in diagnosis and treatment. When a disease has been diagnosed—traced to its ultimate cause—treatment becomes plain, whether it be by active surgical interference or otherwise. Surgical interference clearly calls for special aptitude and practice, and for specially-adapted surroundings and appliances, all of which can never be within the reach of the body of the profession; but no man has a right to practice medicine who is not in a position to make a rational diagnosis in every case, quite irrespective of the part of the body affected.

Let medical education, then, be conducted in such a way that there may be no mystery attaching to any particular part of man, nor to any particular group of diseases. Let every patient who presents himself be treated as he will have to be afterwards treated in general practice, so that every student may understand always that the nasal, aural, and vaginal speculum, the laryngoscope and the ophthalmoscope, are his property, and that he must use them just as he would the thermometer, the stethoscope, or the urinometer.

South Petherton. S. W. MacILWAINE.

Surgery in the West of Europe.

The other day I was at a small town on the sea coast, and seeing a crowd around a chemist's shop, I pushed my way in out of sheer curiosity. A boy of about 15 or 16 was sitting in a chair with a hand-basin on his knees, and bleeding a little from a wound in the middle finger of his left hand.

Two men, the local doctor and the chemist, were in attendance; the former pushing something pointed into the wounded finger, the latter looking after the basin.

On enquiry, I found that the boy had been out shooting, and lodged the contents of a charge in his finger.

I managed to get near enough to speak to the doctor, and was permitted to look at the finger, but not to touch it. There was an attempt at a tourniquet, consisting of a very thin piece of tape tied loosely round the wrist; the joint between the first and second phalanges of the middle finger were simply in a jelly, and studded with small shot. The "something pointed" turned out to be a small caustic-holder containing silver nitrate, and the doctor told me that as he was unable to find the bleeding vessels he was cauterizing the wound, and would dress it next day.

In a few minutes he put on his gloves without washing his hands, lighted a cigarette, and left, evidently very proud of what he had done. The boy was told to see the doctor on the next morning, and went out of the shop much as he had come in, but carrying away with him some silver nitrate about his finger.

No attempt at dressing, or even bathing the finger, had been tried, and the pieces of tape hanging loosely round the wrist was the only evidence that the boy had been seen by anyone professing to have some surgical knowledge.

Oporto. W. F. C.

Notes from Country Practice.

Scene :—A very dilapidated cottage, front door ill-fitting and opening directly into a low-pitched room, size about ten feet by eight feet, in the corner of which is a low bedstead, clothes dirty and tattered, literally nothing in the room; the occupant was a woman, mother of five children, in the last stage of chronic phthisis. Doctor had been asked to visit her because her husband "don't like the looks of her." Having seen the extent of their poverty, the husband was told to come up to the doctor's house for some nourishment, and on the way was asked how they managed to *live*. The reply, given with infinite pathos, was "Live sir, we *don't* LIVE, we only sort o' bides about."

An old man suffering from rectal carcinoma, applied for something to relieve the intense pain. A dozen morphia suppositories, gr. ij. each were given to him, with full and clear directions for use. At the end of a week he turned up, highly delighted, and asked for "some more of them *big* pills." It transpired that he had swallowed two daily, and nothing would convince him that they were intended to be taken into the system at the other end of the alimentary canal, for, as he put it, "they done very well taken *his* way."

Primitive Midwifery.—Some years ago an old monthly genius sent for doctor to see a multipara in labour. With great pride she informed him "she had got a leg." This turned out to be an arm, which she had securely fastened with a piece of stout clothes-line to the bed-post; version was performed without anæsthetic; mother and child did well, and are alive at the present time.

L. S.

Nursing News.

List of Probationers and Lady Pupils who passed their Surgical Examination on November 29th, 1894:—

Anson	Fraser	Orgias
Ballantyne	Freeman	Pooley
Baylis	Garland	Press
Brewer	Goucher	Sadler
Brown, S.	Grange	Seaman
Chester	Hanmer	Smith, T.
Chippendall	Healy	Skermann
Clarke, S.	Hill	Stowell
Coombs	Hornfray	Taylor
Coupland	Huck	Thornhill
Creighton	Lawrence	Tillott
Davidson	Leng	Timbrell
Davis	Löhmann	Weymouth
De Bulmer	Lushington	Woods
Douglas	Mansell	Woodward
Dupius	Moles	Worthington
Foggo	Ogilvie	Wiltshire

Names of the Probationers who have gained the highest marks in the three last Examinations, and have been awarded the Cazenove Prizes :—

1. De Bulmer.
2. S. Clarke.
3. Skermann.

This is the first year of the "Cazenove" Prizes which have been endowed by the family of our late Governor, the Rev. Canon Cazenove, to perpetuate his memory and the interest he always took in the happiness and welfare of our Nursing Staff. Each prize-holder is entitled to a full course of Pharmacy lectures and practical Dispensing classes.

We are glad to learn that Miss Evelyn Hurlbutt has been appointed Matron of the Reynard Hospital. She enters on her new duties early in January.

Metropolitan Asylums Board.

MEDICAL INSTRUCTION AT FEVER HOSPITALS.

NOTICE TO STUDENTS.

A Course of Instruction in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals, as follows :—

EASTERN HOSPITAL, The Grove, Homerton, E. (Dr. E. W. Goodall, Resident Medical Superintendent), on Tuesdays and Fridays, at 11 a.m., commencing Tuesday, 8th January, 1895.

WESTERN HOSPITAL, Seagrave Road, Fulham, S.W. (Mr. R. M. Bruce, Resident Medical Superintendent), on Tuesdays and Fridays, at 11 a.m., commencing 8th January, 1895.

SOUTH-WESTERN HOSPITAL, Landor Road, Stockwell, S.W. (Dr. F. F. Caiger, Resident Medical Superintendent), on Tuesdays and Fridays, at 11 a.m., commencing Tuesday, 8th January, 1895.

SOUTH-EASTERN HOSPITAL, Hatfield Street, New Cross, S.E. (near Old Kent Road Station, L. B. & S. C. Railway.) (Dr. J. MacCombie, Resident Medical Superintendent), on Tuesdays and Fridays, at 11 a.m., commencing Tuesday, 8th January, 1895.

N.B.—Students desiring to attend a Course of Instruction are required to bring their authority from the Dean of the School to the Clerk of the Metropolitan Asylums Board, Norfolk House, Norfolk Street, Strand, W.C., on any week-day (except Saturday) between the hours of 11 a.m. and 4 p.m.

The fee for the Course of Instruction is £3 3s. for two months, and £1 1s. for each month afterwards; and Students will be required to observe the Rules and Regulations laid down for their guidance by the Local Government Board and the Metropolitan Asylums Board.

Voces Populi.

[Scene.—*St. Paul's Ward, 6 a.m. Patient with phthisis of fifteen years' duration has just succeeded in crossing that bourne whence no traveller returns. H.-P. arrives with hasty strides, examines lungs, heart, abdominal viscera, larynx, etc., feels diagnosis is moderately certain, gives strychnine injection and retires*].

Convalescent patients conversing:

1st Patient.—Doctor soon finished him orf, didn't he, Bill?

2nd Patient.—Why that he did, but which doctor was it?

1st Patient.—Why him they call *The Large White Un*, or *Sassages* for short sometimes; 'taint the first one either, and I guess it won't be the last.

2nd Patient.—Why do they call him *Large White?*

1st Patient.—Well, I guess it's because he *is* Large White, though some do say it's because his kidneys ain't right, and some says he's got toobal knee-frightes.

[Scene.—*St. Elizabeth's Ward, 3 p.m. Group around case of typhoid fever, some standing, others sitting on bed, others buttressing themselves up by putting feet on bedstead. Head Physician pursuing Socratic method of asking questions*].

Physician.—Well, Mr. Sniggersby, what's your diagnosis?

Mr. S.—Typhoid fever, sir.

Head Physician.—Yes, I think we may diagnose *Fever*, at all events, with moderate certainty. Why do you think it's typhoid?

Mr. S.—Because she's got spots.

Head Physician.—Yes, so have a good many other people. Still, I daresay you're right. Supposing it to be a case of typhoid, what other symptoms would you expect to find during the first week?

Mr. S. (*quite innocently*).—Bedsores (*sensation*).

[*Physician passes on to next case, one of bad heart disease, with innumerable bruits audible in all directions.*]

Physician (*after prolonged examination*). — Well, Mr. Snookpot, what's your diagnosis?

Mr. S.—Mitral stenosis, sir, with other valvular lesions.

Physician.—Oh, now you mustn't expect to be too accurate, you know, else we shall be making mistakes; much better always to diagnose too little than too much. Well, your diagnosis is mitral stenosis, my diagnosis is Dropsy, probably not due to renal disease, hepatic disease, myxœdema or anæmia, but possibly due to morbus cordis, with secondary hepar auctum. And the treatment, Mr. S.?

Mr. S.—Light, easily-digested food and aperients.

Physician.—Well, Mr. Snookpot, do you think any one would thank you for giving them indigestible food or constipation? [*Exit Mr. S.*]

[*Next case a marasmic infant, aged three weeks*].

Physician (*reading from Ward clerk's report*).—Patient was admitted for "uppards and downwards, wasting away, and general debility." Family History.—Patient is the only survivor of eight children, all the others having died comparatively young. The eldest was a beautiful boy born, but all of a sudden he seemed to catch his breath up so that there was no life left in him, and fell away wonderful-like, in fact he seemed to waste away all to nothing, and then he come out with a gum-rash all over him, though some did say it was the glass-pock. He was treated with saffron powders, which brought a deal of humour out of him. In spite of this he never seemed to be quite himself again, and pined away and died just as he seemed to be getting over it. The others all seemed to sort of take the complaint from him as it were. One was very bad with the screaming convulsions, and another had a sort of affection, as it were, of the bowels (so the doctor said). Patient's father and mother are, and have always been, very healthy. Patient's father had a paralytic stroke six years ago, and has since suffered from fits. Patient's mother is very subject to feverish colds on the chest, spits up a deal of thick yellow stuff, sweats wonderfully of a night, and loses flesh cruelly. She has a nasty cough at present, which do hack night and day. Personal Medical History.—Patient was a fine healthy child up to the day before admission. All of a sudden she seemed to lose her little self, as it were, then she clenched her little fists and seemed to take a strong convulsion inwardly. During the eclamptic seizure it was noticed that the optical axes diverged slightly and were rotated upwards through an angle of 52°, so that the sclerotics alone were visible. The cortical discharge appeared to commence with a spasmodic movement of abduction of the left forefinger. In any case the cerebral condition appeared to be one of extreme neurotonic instability.

Physician.—Thank you, Mr. Slingsby, that is a very excellent and accurate report, but I think it would be all the better for being translated into and from the vernacular in places (*Applause from invidious fellow ward clerks*). [*Curtain*].

Some Out-patient Cases presenting interesting features.

Two Cases of Congenital Lumbar Hypertrichosis.—Patients are sisters, the third and seventh children of a family of seven; the remainder are unaffected. Both parents are English, and the hirsuties dates from birth in either case; the condition of the elder child as an infant is identical with that of the younger at the present day. The elder of the two girls, aged 10, has in the lumbar region a triangular patch, base upwards, of fine silky golden hair; the base of the triangle reaches a level one inch above the highest point of the iliac crest,

and the apex is one inch above the gluteal cleft. The hair, which is directed downwards, is of a slightly lighter tint than that of the scalp, and attains a length of five inches; there are no dental defects. The younger patient presents the same condition as her sister, but in a much less degree. The elder is the subject of old infantile paralysis of the right leg, causing local peripheral gangrene and talipes equinus. There is no sign of spina bifida occula, or perforating ulcer (see *Lancet*, July 2nd, 1887).

Raynaud's Disease: *one hand attacked twelve months before the other.*—C. Y., æt. 61, a woman of a neurotic temperament, noticed for the first time, two years ago, that the little finger of the left hand used to grow white, cold and insensible to touch; gradually the other fingers of the same hand became affected, but it was only twelve months ago that the right hand was first attacked, commencing, as in the left hand, in the little finger, and spreading to the others later. At the present time all the fingers of the left hand are more or less shrivelled at their extremities and present small cicatrices; they are swollen and livid, but there is no marbling of the hands; the fingers of the other side are cold and blue, but there is no scarring. The left big toe is similarly affected, but not the other toes, nor the nose, ear or tongue. There is no sclerodermia. The condition is never completely absent, but the attacks are paroxysmal and worse in winter. Cold is sometimes an exciting cause, but at other times attacks seem to arise independently; they last some time, but warmth certainly shortens their duration, and recovery is attended with a good deal of pain. There is no history of ague or hæmaglobinuria.

Treatment.—The hands have been immersed, each for five minutes, three times a week, in water, and a current passed through. She has been ordered to wash in warm water and wear thick gloves, and she has taken Tr. Opii ♏iii. three times a day. She declares she has decidedly improved under this treatment.

Habit Spasm.—The subject of this neurosis was a girl of 22. It commenced at about the age of six, and it is thought arose from imitation of one of her governesses at school; she was always a nervous child; has had no other illness, and has not been overworked; there is no neurotic family history. Ever since childhood she has had a habit of abruptly nodding her head up and down, two or three times every few minutes, worse when she is wearing a hat; the movements have a semi-voluntary aspect, but are only slightly under the control of the patient. There is no other spasm of any other muscles.

Labyrinthine Vertigo. — Patient complained of vertigo accompanied by tinnitus and deafness. The vertigo came on for the first time a day after her confinement about two months ago. The attacks, which are paroxysmal, are excited usually by fatigue, and occur three and four times daily. Up till recently they were preceded by tinnitus; now tinnitus is constant. She always falls forwards in the fits of giddiness, never loses her senses, and afterwards feels a sensation of retching, but never vomits. She also experiences subjective sensations of vertigo—objects then seeming to move in all directions. There is no nystagmus; the tinnitus and deafness are mainly on the right side. Pot. Brom. gr.x., Pot. Iod. gr.iii. t.d.s. has much improved the giddiness. She has not fallen down once since commencing to take this.

L. A. PARRY.

Appointments.

The following appointments have been made by the Treasurer:—

House-Physicians.—Mr. L. A. Parry (Dr. Taylor); Mr. A. P. Allan (Dr. Goodhart).

House-Surgeons.—Mr. D. M. Beddoe (Mr. Lucas); Mr. V. Pendred (Mr. Golding-Bird).

Assistant House-Physicians.—Messrs. A. H. Leete, and E. A. Peters.

Assistant House-Surgeons.—Messrs. E. C. Taylor, and H. W. Beach.

Resident Obstetrics.—Messrs. S. Copley (January); C. E. Carpmael (February); L. Slater (March).

The following appointments have been recommended by the Medical Council, and approved by the Treasurer:—

Clinical Assistants.—Messrs. L. E. V. Every-Clayton, F. J. Steward, A. C. Hovenden, G. S. Hovenden, T. M. Thomas, A. A. H. Partridge.

Dressers in the Eye Wards.—Messrs. A. V. Clarke, E. E. Henderson (Mr. Higgens) (January); E. Coleman, A. Salter (Mr. Brailey) (January); J. C. Constable, J. R. Steinhaeuser (Mr. Higgens) (March); R. H. Hayes, E. T. Shorland (Mr. Brailey) (March).

Surgeons' Dressers.—Messrs. E. T. Scowby, A. H. H. Huckle, H. P. Ferraby, J. Robertson, M. H. Smith, C. C. Stead, (Mr. Howse); C. D. Edwards, T. L. Jackson, C. Coventry, L. C. Panting, T. W. Stanton, W. Tyson (Mr. Davies-Colley); C. J. Harnett, J. J. Foster, C. G. Burton, P. J. Curtis, W. W. Farnfield, P. H. Haylett (Mr. Lucas); H. Fulham-Turner, E. J. Maxwell, W. G. Mitchell, M. E. Tresidder, N. Daly, J. C. G. Reed (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. C. H. Fagge, A. Earnshaw, A. G. Butler, N. H. Pike, A. H. Spicer, E. F. Clowes (Mr. Jacobson); W. I. Hancock, J. B. Parfitt, A. E. Porter, T. W. Ta'Bois, H. Bernard-Onraët, A. T. Falwasser (Mr. Symonds); E. Moore, W. R. Davies, A. J. Wernet, S. C. Clapham, F. C. Hitchins, J. T. Roberts (Mr. Lane); C. C. A. Salmon, J. Dixon, Ed. Evans, A. H. Finch, W. A. Fuller, E. H. Pomeroy (Mr. Dunn).

Medical Ward Clerks.—Messrs. E. Fisk, H. W. Dudgeon, W. E. Plummer, T. B. Poole, B. B. Gough, C. E. Michael, A. B. Carter, M. C. Hayward, F. G. Thomas, R. Mathias,

V. E. Collins, G. Burton-Brown, H. T. Hicks, R. Howard, J. Howell, H. Leader, A. W. Ormond, F. Golding-Bird, R. Kay, C. R. Evans, J. N. Gardiner, B. Instone, N. Lavers, N. Y. Lower, D. Rice, R. P. Rowlands, E. I. Spriggs, C. P. Weekes, C. T. Anderson, W. C. Pritchard, W. F. Reckitt, H. Simson.

Assistant Physicians' Clerks.—Messrs. E. A. Prebble, W. T. Clarke, H. E. Izard, C. R. Nicholson (Dr. Pitt); W. J. Henson, W. E. Hills, S. Whicher, W. R. Wood (Dr. Shaw); C. W. Booker, L. T. A. Rowland, H. V. Smith, G. E. Duncan (Dr. Washbourn).

Aural Surgeon's Dresser.—Mr. H. A. Moffat (January).

Dental Surgeons' Dressers.—Messrs. C. J. Kearney (January); J. W. Bird (February).

Dressers in the Throat Department.—Messrs. R. H. Moon, F. A. Evison, C. E. Cooper, H. A. Moffat, W. J. Rowland, E. H. Van Someren, A. P. Beddard, C. S. Bond.

Post-Mortem Clerks.—Messrs. F. Zumbado, P. C. Prince (January); W. S. Handley, R. E. Delbruck (February); F. A. Godson (March).

Obstetric Ward Clerks.—Messrs. G. Lawrence, P. G. Temple.

Obstetric Out-Patients' Clerks.—Messrs. L. H. Y. Stephen, G. Gocher (first half); F. W. Rowland, B. W. M. A. Key (second half).

Surgical Ward Clerks.—Messrs. D. B. Todd, J. Moore, R. B. Stamford, T. J. Vick, C. A. C. Askew, G. K. Levick, G. B. Pearson, A. E. B. Crosby, J. H. Jones, R. J. Rowland, R. S. Rowland, M. H. Way, C. C. Worts, A. H. Bell, J. M. Fortescue-Brickdale, W. C. Milward.

Assistant Surgeons' Clerks.—B. B. Ham (Mr. Jacobson); J. B. A. Treusch (Mr. Symonds); H. Fulton (Mr. Lane); J. G. Watt (Mr. Dunn).

Clerks to Anæsthetists.—Messrs. H. Alexander, E. H. van Someren, F. H. Hardy, J. W. Bird, W. S. Handley, G. H. Field.

Externs.—Messrs. E. T. Scowby, B. W. M. A. Key, A. A. Price, L. C. Panting, M. H. Smith, C. C. Stead, E. N. Scott.

The following Dental appointments have been recommended by the Dental Committee, and approved by the Treasurer:—

Dental House-Surgeons.—Messrs. U. E. Cave, F. E. L. Lambert.

Assistant Dental House-Surgeon.—Mr. D. S. Stevens.

Demonstrators in Conservation Room. — Messrs. N. Denham, E. C. Dimock, E. R. Tebbitt.

Curator of the Laboratory.—Mr. N. Snell.

Marriage.

CARLING—HARWOOD.—On December 18th, at the Free Christian Church, Croydon, William Carling, M.B., Highland Road, Southsea, to Lucy, daughter of the late W. R. Harwood, of Glebelands, Mitcham.

Pass List.

University of London, December, 1894.

M.D. EXAMINATION.

MEDICINE.

Floyd, S. G.	Norburn, A. E.
Howard, J. A.	Pantin, C. S.
Jewell, J. W. F.	Sharp, A. J.
Johnson, W. J.	Swayne, W. C.
Kemp, G. L.	Taylor, Tom R.
Lister, T. D.	Young, J.

STATE MEDICINE.

Hogarth, B. W.

M.S. EXAMINATION.

Webber, H. W.

B.S. EXAMINATION.

FIRST DIVISION.

Carpmael, C. E.	Hovenden, G. S.
Clarke, J. St. T.	Huntley, E.
Davies, Hugh	Taylor, E. C.

SECOND DIVISION.

Adams, E. L.	Hovenden, A. C.
Allan, A. P.	Manning, T. D.
Collier, H. W.	Steward, F. J.

Review.

In a House of Pain. By Frederick Vynon (Remington and Co., London and Sydney). Price 3s. 6d.

In the opening chapter of this romance we are introduced to scenes and characters which seem to us to belong unmistakably to Guy's Hospital. Thus, in the first few lines the reader is taken to "an oak-panelled room on the second floor of the vast and irregular building of a London hospital." From the graphic description of this apartment, many generations of Guy's house-surgeons and dressers will recognise "the rooms," and we have the type of a popular house-surgeon presented to our notice in Frank Loftus, while in Charlie Phillips, the friend with whom he is conversing, we have a muscular cynic, with many redeeming qualities. On this night they were discussing women as nurses. Loftus had ventured to suggest that a good nurse should make a good wife. Phillips chuckled to himself. "My dear fellow," he said, "they know too much, the whole mystery of nursing is to disillusion one's self, if I may make a 'bull,' to become hardened, and to entrap a husband." "Nonsense," answered Loftus, "there is the 'mission' point of view, too." The story consists in the practical application of these opposing opinions in the subsequent history of the lives of the two men, and of the women with whom their destinies eventually become interwoven. From the open windows of the rooms the two friends are attracted by the sounds of evening service in the chapel, from which

"a procession of women in sombre but picturesque costume slowly filed." Evelyn Manton, "in the black garb that denoted the 'lady probationer,'" is among them, and as he gazes at her form disappearing up the colonnade steps, Frank Loftus exclaims, "There, I'll swear, is a true woman." How she proved herself such, how Charlie Phillips was cured of his cynicism, and for a vivid presentation of the tragic side of a life of pleasure, with the ultimate fate of the chief characters, we must refer our readers to the pages of the work. During the course of the story we meet with many familiar members of the Staff and officials about the Hospital, who to us are but slightly disguised under such soubriquets as "Mr. Jamison, one of the surgeons," "Mrs. Kane, the night surgery nurse," and the "lively little nurse Penelope," on whom we are of opinion the author has unconsciously, perhaps, been a little hard. "The senior surgeon, Mr. Burnham," and even his old coachman, "who was a character" in his way, are not forgotten. "Dr. Figg-Brown walked through, glancing first at the notices on the wall, after him came 'the Grand Old Man' of the Hospital, Dr. Dilkes, the great pathologist," and so on.

Frederick Vynon has written his book in good style, though we cannot help feeling that to other than Guy's men much of the local incident is devoid of interest. The story itself is told with a frankness of *la morgue littêraire* which is decidedly pleasing, and the author in his little sallies at the peculiarities of the public characters portrayed in this novel proves himself to be possessed of that rare but happy power of giving expression to the incidents of common experience, of what we can all see, but after a dumb manner.

Notices.

HOME-MADE SURGICAL INSTRUMENTS.

Messrs. Allen & Hanburys, of Plough Court, Lombard Street, E.C., have sent us particulars, to which it gives us much pleasure to give publicity, of the special provision they are now making for the advantageous supply of Surgical Instruments and Surgical and Medical Appliances. Having obtained the co-operation of a thoroughly practical superintendent and a staff of technically-skilled and experienced workmen, they now manufacture steel and other instruments at their own works at Bethnal Green, and can thus guarantee excellence both of material and workmanship, and are in a position to effect repairs with despatch. With the view of bringing this department more immediately and conveniently into connection with members of the profession, they have opened a depôt at 48, Wigmore Street, W., where a large and varied stock will be found, including the most recent introductions from the Continent and the United States, and the general arrangements appear to be such as to conduce to the best convenience of customers. Messrs. Allen & Hanburys' great reputation is not likely to suffer from their latest enterprise.

JOHANNIS.

We have received a particularly clever group of Fancy Ball Dress designs from the Johannis Company, Limited, which is being distributed as a Christmas souvenir amongst their customers. Like Johannis Water itself, they are of superlative excellence. Beautifully executed in at least a dozen colours, these cards offer excellent and original suggestions for fancy ball costumes. We would strongly advise any of our readers whose inclinations lean in this direction, to immediately write for a complete set, as they are the copyright of the Johannis Company, Limited, 25, Regent Street, S.W., and the demand is sure to be brisk and extensive.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

R. S. S.—The deep ulcer of pyloric end of stomach is surrounded by inflammatory and cicatricial changes. There is catarrhal changes in some of the glandular tubules, but no structural cancer.

S. B. S., Walthamstow.—The gland sent shows chronic inflammation leading to caseation, and is probably, therefore, tuberculous. No definite proof can be adduced, however. There were no nodules, nor were tubercle bacilli to be found. Inoculation might settle the question, however.

H. W. D., Croydon.—The sac sent consists of several connective tissue lamellæ. Subperitoneal fat is present in some quantity. It is impossible to say from the long duration of the hernia whether this is of omental origin or not. There are a few inflammatory changes, especially in the fat.

B., East Croydon.—Carcinoma mammæ, with well-developed connective tissue.

H. C., Saxmundham.—Tubercle bacilli are present.

F. H. D., Fir Caradoc.—Tubercle bacilli are present.

H. E. C., Liss.—Tubercle bacilli are present.

PATHOLOGIST

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GUY'S HOSPITAL MEDICAL SCHOOL